REQUESTING TRANSFER FROM:_______________________________(School district/Former Employer)

GROUP NUMBER: ______________________________

Enrollment — Voluntary

Group Name

Delta Group/Division Number

A ENROLLEE (Complete this section for new enrollment or change of status)

Name ____ Last ____ First ____ Middle Initial

Social Security Number ____-____-____ (Member I.D. Number)

Date Employed ____/____/____ Month Day Year

Action Requested
- ☐ New enrollment
- ☐ COBRA enrollment
- ☐ Change in enrollment
- ☐ Reinstatement
- ☐ Transfer
- ☐ Rehire

Please enroll me in the following:
- ☐ Delta Dental
- ☐ Delta Vision

Birthdate Month Day Year ____/____/____

Sex ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated

Do you have dependent children? ☐ Yes ☐ No

Does your spouse have a dental plan? ☐ Yes ☐ No
If yes, who is covered: ☐ yourself ☐ spouse ☐ dependent children
If Delta Dental, indicate group number: ____________

Employee Classification
- ☐ Certificated
- ☐ Classified
- ☐ Salaried
- ☐ Full-time
- ☐ Hourly
- ☐ COBRA
- ☐ Part-time
- ☐ Retired

Mailing Address ______________________ Telephone Number (____)______________

City ______________________ State ______________ ZIP code ____________

FOR DELTA USE ONLY

Effective Date of Coverage

Family Indicator Code

☐ **COBRA Enrollment**

I understand that I may be required by the employer to pay for COBRA benefits

Note: If Dependent is enrolling under own social security number, the original Member's social security number must be supplied.

____
Benefits previously received under Social Security Number (Member I.D. Number)

Qualifying Date ____/____/____ Month Day Year

B Change to Existing Enrollment (Complete all sections that apply)

☐ Name change ☐ Add new dependent ☐ Delete dependent ☐ Address change listed above

Reason for change ______________________ Effective date of change ____/____/____ Month Day Year

C DEPENDENTS (Complete for new enrollment or to add or delete dependents)

Spouse Name Last (if different)	First	Middle Initial	**Add/ Delete**	**Sex** M F	**Birthdate** Month Day Year	**Marriage/Divorce Date** Month Day Year		**Spouse's Social Security Number**
					____/____/____	____/____/____		
Child Name Last (if different)	First	Middle Initial	**Add/ Delete**	**Sex** M F	**Birthdate** Month Day Year	If Child is 19 years or older (check one) **Full-time Student**	**Disabled**	**Child's Social Security Number**

D Signature (Form must be signed to be processed)

I understand that I may be required by the employer to pay for these benefits. I agree to continue membership in this program during employment and while the program is in force and I agree to comply with the terms of the group contract.

Enrollee Signature ______________________________ Date ______________

Delta 602A (rev. 5/05)