

Enrollment – Non Voluntary

Group Name _____	Delta Group/Division Number _____
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A | ENROLLEE (Completes this section for new enrollment or change of status)

Name			Social Security Number		Date Employed			Action Requested			Please enroll me in the following:									
_____/_____/_____			_____-_____-_____		____/____/____			<input type="checkbox"/> New enrollment <input type="checkbox"/> COBRA enrollment <input type="checkbox"/> Change in enrollment			<input type="checkbox"/> Reinforcement <input type="checkbox"/> Transfer <input type="checkbox"/> Retire			<input type="checkbox"/> Delta Dental <input type="checkbox"/> Delta Vision						
Last	First	Middle Initial	(Member I.D. Number)		Month	Day	Year													
Birthdate			Sex		Marital Status		Do you have dependent children?		Does your spouse have a dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			Employee Classification								
____/____/____			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Domestic Partner		<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, who is covered: <input type="checkbox"/> yourself <input type="checkbox"/> spouse <input type="checkbox"/> dependent children			<input type="checkbox"/> Certificated <input type="checkbox"/> Classified <input type="checkbox"/> Salaried			<input type="checkbox"/> Full-time <input type="checkbox"/> Hourly <input type="checkbox"/> COBRA			<input type="checkbox"/> Part-time <input type="checkbox"/> Retired		
If Delta Dental, indicate group number: _____																				

Mailing Address _____ Telephone Number _____ ()										FOR DELTA USE ONLY					
City _____ State _____ ZIP code _____										Effective Date of Coverage					
<input type="checkbox"/> 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) _____										Family Indicator Code					
										Qualifying Date _____ / _____ / _____ Month Day Year					

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

<input type="checkbox"/> Name change	<input type="checkbox"/> Add new dependent	<input type="checkbox"/> Delete dependent	<input type="checkbox"/> 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	Birthdate	Marriage/Divorce Date	Spouse's Social Security Number
				M <input type="checkbox"/> F <input type="checkbox"/>	Month _____ Day _____ Year _____	Month _____ Day _____ Year _____ If Child is 19 years or older	
Child Name (Last (if different))	First	Middle Initial	Add/Delete	Sex	Birthdate	Full-time Student	Child's Social Security Number
				M <input type="checkbox"/> F <input type="checkbox"/>	Month _____ Day _____ Year _____	<input type="checkbox"/>	
				M <input type="checkbox"/> F <input type="checkbox"/>		<input type="checkbox"/>	
				M <input type="checkbox"/> F <input type="checkbox"/>		<input type="checkbox"/>	
				M <input type="checkbox"/> F <input type="checkbox"/>		<input type="checkbox"/>	
				M <input type="checkbox"/> F <input type="checkbox"/>		<input type="checkbox"/>	
				M <input type="checkbox"/> F <input type="checkbox"/>		<input type="checkbox"/>	

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 contact.

Enrollee Signature _____ Date _____