DELTA DENTAL®

Delta Dental Plan of California

Enrollment

Group Name TAMALPAIS UNION HIGH SCHOOL DISTRICT

Delta Group/Division Number 7302 - 1701

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
- ☐ Reinstatement
- ☐ COBRA enrollment
- ☐ Transfer
- ☐ Change in enrollment
- ☐ 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
- ☐ Full-time
- ☐ Part-time
- ☐ Classified
- ☐ Hourly
- ☐ Retired
- ☐ Salaried
- ☐ COBRA

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 there is no contribution required by me for coverage of myself or my dependents. (Exception — See COBRA enrollment) 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 ____