DELTA DENTAL®

Enrollment — Voluntary

Group Name: Dunn Construction

Delta Dental Group/Division Number: 001

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
- [X] New enrollment
- [ ] COBRA enrollment
- [ ] Change in enrollment
- [ ] Reinstatement
- [ ] Transfer
- [ ] Rehire

Please enroll me in the following:
- [X] Delta Dental
- [ ] DeltaVision®

Birthdate (Month Day Year) ___/___/___

Sex
- [ ] Non-binary
- [ ] 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
- [X] 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.

_____ Qualifying Date ___/___/___
Benefits previously received under Social Security Number (Member I.D. Number) (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 N 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 N 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 _____