DELTA DENTAL®

Enrollment - Change

Group Name Fallbrook Union High School District

Delta Dental Group/Division Number 07028 - 01601 & 01602

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
(select one)

Please enroll me in the following:
☒ Delta Dental
☐ DeltaVision®

Birthdate
Month Day Year

Sex
(select one)

Marital Status
(select one)

Do you have dependent children?
(select one)

Does your spouse have a dental plan? (select one)

If yes, who is covered: (select one)

If Delta Dental, indicate group number: _____

Employee Classification
(select one) (select one)

Mailing Address _____ Telephone Number (_____) _____

City _____ State _____ ZIP 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

FOR DELTA DENTAL USE ONLY

Effective Date of Coverage

Family Indicator Code

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**	If Child is 19 years or older (check one) **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 _____