

Enrollment - Change

ENROLLEE (Complate this section for new annellment or change of status)	Group Name Fallbrook Union High School District						07028 - 01601 & 01602			
Social Security Number Date Employed Action Requested Please enroll me in following: Delete Penis	A ENDOLLEE (Complete this continue for any annual formation of the continue for any and any any and any and any and any any and any any and any any and any and any any and any any and any any any and any any and any any any an									
Delta Vision Delt		Social Security Number		D	Date Employed		Action Requested			
Effective date of change Complete of security Number (Member LD. Number) Delete dependent Delete Delet		_			/ /					
Mediting Address	Last First Middle Initial	(Member I.D. Number) Month Day			th Day Year					
Malling Address	Month Day Year dependent	If yes, who is covered:			,			Employ	yee Classification	
Mailing Address (elephone Number (If Delta Dental, indicate gr	roup numbe	r:						
COBRA Enrollment Tunderstand that I may be required by the employer to pay for COBRA benefits	Mailing Address	Telephone Number ()								
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 LD. Number) **B** Change to Existing Enrollment (Complete all sections that apply) Reason for change Add new dependent Delete dependent Address change listed above	City State ZIP code									
Understand that I may be required by the employer to pay for COSIKA benefits									Effective Date of Coverage	
Benefits previously received under Social Security Number (Member I.D. Number) Complete Sproiliment (Complete all sections that apply)	I understand that I may be required by the employer to pay for COBRA benefits									
B Change to Existing Enrollment (Complete all sections that apply) Reason for change	Note: If Dependent is enrolling under own social security number, the original Member's social secu	urity number must be supplied	d.						Family Indicator Code	
Reason for 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 N M F Month Day Year Month Day Year Social Security Number Child Name Last (if different) First Middle Initial Delete N M F Month Day Year Month Day Year Month Day Year Social Security Number Child Name Last (if different) First Middle Initial Delete N M F Month Day Year Month										
Effective date of change	B Change to Existing Enrollment (Complete all sections that apply)									
C DEPENDENTS (Complete for new enrollment or to add or delete dependents) Spouse Name Last (if different) First Middle Initial Add/ Delete N M F Month Day Year Child's Social Security Number Child's Social Security Number Disabled Social Security Number Social Security Number	□ Name change □ Add new dependent □ Delete dependent	☐ Address change listed a	bove							
C DEPENDENTS (Complete for new enrollment or to add or delete dependents) Spouse Name Last (if different) First Middle Initial Add/ Delete N M F Month Day Year Child's Social Security Number First Middle Initial Marriage/Divorce Date Month Day Year Month Day Year Month Day Year Child's Social Security Number Full-time Student Disabled Social Security Number Disabled Social Security Number Disabled Social Security Number	Reason for change				Effective	date of cha	nge	/_	Day Year	
Spouse Name Last (if different) First Middle Initial Add/ Delete N M F Month Day Year Social Security Number First Middle Initial Add/ Delete N M F Middle Initial Add/ Delete N M F Month Day Year If Child is 19 years or older (check one) Child's Social Security Number Child's Social Security Number Disabled Spouse's Social Security Number Child's Social Security Number Disabled Spouse's Social Security Number										
Child Name Last (if different) First Middle Initial Add/ Delete N M F Month Day Year Full-time Student Disabled Social Security Number Child's Social Security Number Disabled Social Security Number	Spouse Name									
Last (if different) First Middle Initial Add/ Delete N M F Month Day Year Full-time Student Disabled Social Security Number Child's Social Security Number D Signature (Form must be signed to be processed)	Last (if different) First	Middle Initial	Delete	Delete N M F Month Day Year Month Day Year S				Social Security Number		
Last (if different) First Middle Initial Delete N M F Month Day Year Full-time Student Disabled Social Security Number	Child Name			Sex	Birthdate					
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Lunderstand that I may be required by the employer to pay for these benefits. Lagree to continue membership in this program during employment and while the program is in force and Lagree to comply	D Signature (Form must be signed to be processed)									
with the terms of the group contract.										
Enrollee SignatureDate										