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DELTA DENTAL®

Delta Dental Plan of California

2022 OPEN ENROLLMENT

# Enrollment — Voluntary

**Group Name**
Santa Monica-Malibu USD

**Delta Group/Division Number**
006741-0101

## 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 ☐ Classified ☐ Salaried
☐ 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.

_____
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** |
|---|---|---|---|---|---|---|---|---|
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## 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 _____