Print Form

DELTA DENTAL

Enrollment — Non Voluntary

Group Name Santa Barbara County Education Office

Delta Group/Division Number 7075-4061 Inentive

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
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	

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 _____