DELTA DENTAL®

Revision Date 01/01/15

Enrollment - Non Voluntary

Group Name	**Delta Group/Division Number**
County Of Humboldt	2613-001

A ENROLLEE (Complete this section for new enrollment or change of status)

Name			**Social Security Number**	**Date Employed**
Last	First	Middle Intial	(Member I.D. Number	Month / Day / Year

Birthdate Month / Day / Year	**Sex**	**Marital Status**	**Do you have Dependent children?**	
/ /	☐ Male ☐ Female	☐ Single ☐ Divorced ☐ Married ☐ Separated	☐ Yes ☐ No	☐ PBIA ☐ Scan ☐ COBRA ☐ Scan

Mailing Address _____ Telephone Number ( )

City _____ State _____ Zip Code _____

Please Note: The first day that you are covered will be the first of the month following the submission of a complete dental enrollment form. You are eligible for dental the first of the month following your hire date. Dependent children are eligible for county dental coverage up to the age of "26" and can be enrolled without requirements - do not have to be a student, or live in your household, or be single.

B Change to Existing Enrollment

☐ Name Change ☐ Add new dependent ☐ Delete dependent ☐ Address change listed above

NOTE: Effective Date is for Benefit Officer to Enter. Please Leave Blank.

Reason for Change - _____ **Effective Date of Change** / /

C DEPENDENTS (Complete for new enrollment or to add or delete dependents)

Spouse Last Name	First	M.I.	Add/Delete	Sex - M/F	D.O.B	Marriage/Divorce Date	Spouse's Social Security #

Child Last Name	First	M.I	Add/Delete	Sex - M/F	D.O.B	If Child is 26 years or older and disabled, indicate:	Child's Social Security #
						☐	
						☐	
						☐	
						☐	

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 _____