**DELTA DENTAL**®
Delta Dental Plan of California

# Enrollment — Voluntary

**Group Name**
Ventura County Deputy Sheriffs' Association

**Delta Group/Division Number**

## 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 ☐ Full-time ☐ Part-time
☐ Classified ☐ Hourly ☐ Retired
☐ Salaried ☐ COBRA

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 _____