Delta Dental Enrollment/Change Form

Name: _____ _____ _____ Social Security Number: _____
Last First MI

Address: _____ _____ _____ _____ _____
Street Apt. City State Zip Code

❑ New Enrollment ❑ COBRA ❑ Add Dependent ❑ Cancel Coverage
❑ Open Enrollment ❑ Remove Dependent ❑ Name Change ❑ Address Change

Select ONE Option: ❑ Employee ❑ Dual ❑ Family

Select ONE Plan: ❑ DeltaCare ❑ Plan 1 ❑ Plan 2

Complete information below for yourself and covered dependents.

							DeltaCare Only	
Relation-ship	**Social Security No.**	**Last Name if different**	**First**	**Middle Initial**	**Sex M/F**	**Birthday Mo/Day/Yr**	**Provider Name**	**Provider Number**
Self								
Spouse								
Child 1								
Child 2								
Child 3								
Child 4								
Child 5								

I understand that my selection may be changed **only** during open enrollment period of each year. Dependent status may be changed only in the case of marriage, divorce, birth, or adoption of a child, death of a spouse or child, loss or gain of spouse's dental coverage, disqualification of a child for dependent coverage.

Signature _____ Date _____

To Be Completed by Human Resource Department

	GROUP	NO.	JCC	COBRA	VPRJ	CAA	MC	WATA
Hire Date	**DC**	2406	0001	0003	0213	0004	0075	0214
	Plan 1	6332	1001	1003	1213	1004	1075	1214
Effective Date	**Plan 2**	6332	2001	2003	2213	2004	2075	2214