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
❑ Remove Dependent ❑ Name Change ❑ Address Change

Select ONE Option: ❑ Single ❑ Dual ❑ Family
Select ONE Plan: ❑ DeltaCare ❑ Preferred Option 1 ❑ Preferred Option 2

Complete information below for yourself and covered dependents.

						DeltaCare Only	
Relation-ship	**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
Hire Date	**DC**	2406	0001	0003	0213	0004	0075
	Pref. 1	6332	1001	1003	1213	1004	1075
Effective Date	**Pref. 2**	6332	2001	2003	2213	2004	2075