ENROLLMENT / CHANGE FORM

DELTA DENTAL of CALIFORNIA and VSP Vision Service Plan

FOR GROUP USE ONLY	
DELTA Group # 007302-	
VSP Group # 30081850-	
HIRE DATE	EFFECTIVE DATE

Enrollee / Change Information

☐ New Enrollment	☐ Marital Status Change	☐ Terminate Enrollee Coverage	☐ SSN / Enrollee ID Correction or previous ID under which benefits rec'd. / /
☐ Add/Delete Dependent	☐ Address Change	☐ Other	

Primary Enrollee Information

Social Security Number / /	Employee ID Number	Date of Birth / /	Gender Male ☐ Female ☐	Marital Status Single ☐ Married ☐
First Name	Last Name			Middle Initial
Mailing Address (Street)		City	State	Zip Code
E-mail Address	Phone Number		Phone Type Cell ☐ Work ☐ Home ☐	

* If a dependent is enrolling under his/her social security number, the SSN currently enrolled under must be provided

ENROLLEE CLASSIFICATION

☐ Full-Time	☐ Certificated
☐ Part-Time	☐ Classified
☐ Hourly	☐ Member / Other
☐ Retired	☐

COBRA (if applicable)

- ☐ Termination
- ☐ Reduction in Hours
- ☐ Divorce/Legal Sepearation*
- ☐ Widowed/Surviving Dependent*
- ☐ Dependent Child No Longer Eligible*

Indicate Qualifying Date: / /

Dependent Information

Relationship	Dependent First Name - Last Name - Middle In.	Add / Term	Social Security #	Date of Birth	Male / Female	Student / Disabled
Spouse / Partner		☐ ☐	/ /	/ /	☐ ☐	☐ ☐
Dependent		☐ ☐	/ /	/ /	☐ ☐	☐ ☐
Dependent		☐ ☐	/ /	/ /	☐ ☐	☐ ☐
Dependent		☐ ☐	/ /	/ /	☐ ☐	☐ ☐
Dependent		☐ ☐	/ /	/ /	☐ ☐	☐ ☐
Dependent		☐ ☐	/ /	/ /	☐ ☐	☐ ☐

☐ I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made if I experience a qualifying family

☐ I authorize any payroll deduction if required towards the cost of this coverage. In the case of COBRA or LOA, I will sent a check payable to NUSD 1 month prior to coverage month.

☐ I decline coverage at this time.

Signature of Enrollee _____ Date: _____