

Group Name _____

Delta Group/Division Number _____

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

Name		Social Security Number	Date Employed	Action Requested	Please enroll me in the following:
Last _____ First _____ Middle Initial _____		(Member I.D. Number) _____	____/____/____ Month Day Year	<input type="checkbox"/> New enrollment <input type="checkbox"/> Reinstatement <input type="checkbox"/> COBRA enrollment <input type="checkbox"/> Transfer <input type="checkbox"/> Change in enrollment <input type="checkbox"/> Rehire	<input type="checkbox"/> Delta Dental <input type="checkbox"/> Delta Vision
Birthdate	Sex	Marital Status	Do you have dependent children?	Employee Classification	
Month ____ Day ____ Year ____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Certified <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Classified <input type="checkbox"/> Hourly <input type="checkbox"/> Retired <input type="checkbox"/> Salaried <input type="checkbox"/> COBRA	
Mailing Address _____			Telephone Number (____) _____		
City _____			State _____ ZIP 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

FOR DELTA USE ONLY

Effective Date of Coverage _____

Family Indicator Code _____

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	Add/Delete	Sex	Birthdate	Marriage/Divorce Date	Spouse's Social Security Number
Last (if different) _____ First _____ Middle Initial _____		M F	____/____/____ Month Day Year	____/____/____ Month Day Year	
Child Name	Add/Delete	Sex	Birthdate	If Child is 19 years or older (check one)	
Last (if different) _____ First _____ Middle Initial _____		M F	____/____/____ Month Day Year	<input type="checkbox"/> Full-time Student	<input type="checkbox"/> Disabled

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 _____