

Group Name County of Sacramento – Active Plan	Delta Group/Division Number 2476 - _____	Effective Date ____/____/____
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A ENROLLEE (Complete this section for new enrollment or change of status)			BENEFITS OFFICE USE ONLY
Name Last _____ First _____ Middle Initial _____	Social Security Number _____ - ____ - ____ <small>(Member I.D. Number)</small>	Date Employed _____ / _____ / _____ <small>Month Day Year</small>	Rep Unit _____ Certs _____ Verified _____
Birthdate Month _____ Day _____ Year _____ <small>Month Day Year</small>	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Employer <input type="checkbox"/> County of Sacramento <input type="checkbox"/> Special District	FOR DELTA USE ONLY
Mailing Address _____ Telephone Number (____) _____ City _____ State _____ ZIP code _____			Effective Date of Coverage _____ Family Indicator Code _____
Does your spouse/domestic partner have a dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who is covered: <input type="checkbox"/> yourself <input type="checkbox"/> spouse/domestic partner <input type="checkbox"/> dependent children If Delta Dental, indicate group number: _____			

B Change to Existing Enrollment (Complete all sections that apply)	
<input type="checkbox"/> Name change <input type="checkbox"/> Add new dependent <input type="checkbox"/> Delete dependent <input type="checkbox"/> Address change <input type="checkbox"/> Return from LOA (Break in coverage) From _____ To _____	<input type="checkbox"/> New Enrollment
Reason for change _____	Date of Event _____ / _____ / _____ <small>Month Day Year</small>

C DEPENDENTS		Add/ Delete	Sex M F	Birthdate Month Day Year	Marriage/Registration Month Day Year	IRS Dependent	Spouse's/Domestic Partners Social Security Number
<input type="checkbox"/> Spouse	<input type="checkbox"/> Domestic Partner					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Last (if different)	First			____/____/____	____/____/____		
Name					<small>If Child is 19 years or older (check one)</small>	IRS Dependent	Child's Social Security Number
Last (if different)	First	Add/ Delete	Sex M F	Birthdate Month Day Year	Full-time Student	Disabled	IRS Dependent
				____/____/____			<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No

D Signature (Form must be signed to be processed)	
I certify the information on this form to be true and accurate to the best of my knowledge and belief, and that any person(s) enrolled is/are my lawful spouse/domestic partner and/or unmarried dependent children and therefore eligible for enrollment in the County Delta Dental as my dependents.	
Enrollee Signature _____	Date _____

White – Delta Dental Yellow – County of Sacramento Pink – Your files

OPEN ENROLLMENT