DELTA DENTAL®

Enrollment Form

Group name **County of Sacramento – Retiree Plan**

Delta Dental group/division number **4063 –** ______________

Effective date ____/____/____

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

Name

____

Last First Middle initial

Social Security Number

_______-_______-_______

(Member I.D. number)

Retiree

☐ Reitree
☐ Reitree + One
☐ Reitree +2+

Birthdate

Month Day Year

_______/_______/_______

Sex

☐ Male
☐ Female

Mailing address ______________________________________

City ______________________ State __________ ZIP code __________

Telephone number (______)______________________

BENEFITS OFFICE USE ONLY

Certs ______________

Verified ______________

FOR DELTA DENTAL USE ONLY

____
Effective date of coverage

____
Family indicator code

B CHANGE TO EXISTING ENROLLMENT (Complete all sections that apply)

☐ New enrollment ☐ Open Enrollment ☐ Name change ☐ Add new dependent ☐ Delete dependent ☐ Address change ☐ *Waive coverage

Reason for change ______________________________________ Date of event _______/_______/_______

Month Day Year

C DEPENDENTS

☐ Spouse ☐ Domestic Partner Last (if different)	First	Middle initial	Add/ Delete	Sex M F	Birthdate Month Day Year	Marriage/Registration Month Day Year		IRS Dependent	Social Security Number
					____/____/____	____/____/____		☐ Yes ☐ No	

Name Last (if different)	First	Middle initial	Add/ Delete	Sex M F	Birthdate Month Day Year	If Child is 19 years or older (check one) Full-time Student	Disabled	IRS Dependent	Child's Social Security Number
								☐ Yes ☐ No	
								☐ Yes ☐ No	
								☐ Yes ☐ No	
								☐ Yes ☐ No	
								☐ Yes ☐ No	
								☐ Yes ☐ No	
								☐ Yes ☐ No	

*If you select the Dental Plan, you must remain in the plan for a minimum of 12 consecutive months before you can waive coverage, or drop dependents. If you add a dependent mid-year, both you and the dependent must remain in the Plan for a minimum of 12 consecutive months before you can waive coverage, or drop dependents. Only a "Qualified Status Change Event" causing a loss of dependent status will allow for a reduction in dependent coverage without fulfilling the 12 consecutive months requirement. *If you waive coverage for yourself or your dependents, you will be eligible to reenroll in the Plan after 24 months.*

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. If applicable, I authorize the County of Sacramento to deduct from my retiree pension the required premiums.

Enrollee signature ______________________________________ Date ______________________