

Group Name <h2 style="margin: 0;">County of Sacramento – Active Plan</h2>	Delta Group/Division Number <h3 style="margin: 0;">2476 - _____</h3>	Effective Date _____ / _____ / _____
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A ENROLLEE (Complete this section for new enrollment or change of status)				BENEFITS OFFICE USE ONLY	
Name		Social Security Number		Date Employed	
Last _____	First _____	Middle Initial _____	_____-_____-_____ (Member I.D. Number)	Month ____/____/____	Day ____/____/____
Birthdate Month ____/____/____ Day ____ Year ____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Employer <input type="checkbox"/> County of Sacramento <input type="checkbox"/> Special District	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: _____		
Mailing Address _____				Telephone Number (____) _____	
City _____				State _____ ZIP code _____	
				FOR DELTA USE ONLY	
				Effective Date of Coverage _____	
				Family Indicator Code _____	

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 ____/____/____ <div style="text-align: right; font-size: small;">Month Day Year</div>	

C DEPENDENTS									
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	Last (if different)	First	Middle Initial	Add/ Delete	Sex M F	Birthdate Month Day Year ____/____/____	Marriage/Registration Month Day Year ____/____/____	IRS Dependent <input type="checkbox"/> Yes <input type="checkbox"/> No	Spouse's/Domestic Partners Social Security Number
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) <input type="checkbox"/> Full-time Student <input type="checkbox"/> Disabled	IRS Dependent <input type="checkbox"/> Yes <input type="checkbox"/> No	Child's Social Security Number
								<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