DELTA DENTAL®
Delta Dental Plan of California

Send completed form to:
DELTA DENTAL (COBRA)
Individual Billing Dept.
233 S. Wacker Drive, #3900
Chicago, IL 60606-6309

Enrollment — Voluntary

Group Name UCSF RESIDENTS/FELLOWS

Delta Group/Division Number 0510-0004

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

Name (Last / First / Middle Initial)

Social Security Number ___-___-___ (Member I.D. Number)

Date Employed ___/___/___ (Month Day Year)

Action Requested
☐ New enrollment ☐ Reinstatement
☐ COBRA enrollment ☐ Transfer
☐ Change in enrollment ☐ Rehire

Please enroll me in the following:
☐ Delta Dental
☐ Delta Vision

Birthdate (Month Day Year) ___/___/___

Sex
☐ Male
☐ Female

Marital Status
☐ Single
☐ Married
☐ Divorced
☐ Separated

Do you have dependent children?
☐ Yes
☐ No

Does your spouse have a dental plan? ☐ Yes ☐ No
If yes, who is covered. ☐ yourself ☐ spouse ☐ dependent children

If Delta Dental, indicate group number: _____

Employee Classification
☐ Certificated ☐ Full-time ☐ Part-time
☐ Classified ☐ Hourly ☐ Retired
☐ Salaried ☐ COBRA

Mailing Address _____ Telephone Number (___) _____

City _____ State _____ ZIP code _____

FOR DELTA USE ONLY

Effective Date of Coverage

Family Indicator 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)

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 (Last (if different) / First / Middle Initial)	Add/ Delete	Sex M F	Birthdate Month Day Year	Marriage/Divorce Date Month Day Year	Spouse's Social Security Number
			___/___/___	___/___/___	

Child 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	Child's Social Security Number

D | Signature (Form must be signed to be processed)

I understand that I may be required by the employer to pay for these benefits. 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 _____