DELTA DENTAL®

Division 00001			Division 00002		
High Plan			Low Plan		
Enrollee Only	$29.26	○	Enrollee Only	$15.68	○
Enrollee + Spouse	$58.52	○	Enrollee + Spouse	$31.33	○
Enrollee + Child(ren)	$58.60	○	Enrollee + Child(ren)	$34.47	○
Family	$93.52	○	Family	$50.93	○

Enrollment — Voluntary

Group Name
DESOTO COUNTY SCHOOLS

Delta Dental Group/Division Number
21097

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
☐

Birthdate
Month Day Year
_____/_____/_____

Sex
☐ Non-binary
☐ 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 N 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 N 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 _____