



Employer Group ENROLLMENT FORM

I am enrolling for: **Dental** **Vision** **Both Dental & Vision**

A. All Employees Must Complete This Section	Name of Firm Where Employed		Occupation		Date of Full-Time Employment				
	Employee Name Last		First		Middle		Phone Number (Home)		
							()		
	Home Address			City		State		Zip Code	
	Social Security Number	Date of Birth	Age	Gender	Marital Status		No. of Eligible Dependents		
				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Not married				
B. Complete this section to select a Dental Provider	View a list of DeltaCare dentists at www.Deltadentalca.org/directory click on DeltaCare Dentist								
	View a list of Davis Vision providers at www.multibenefitplans.com you may go to any Davis Vision provider shown on the website.								
	Please indicate Dental office selected _____ Dental office number from directory _____								
C. Complete this section if you are covering dependents	DEPENDENT INFORMATION								
	Are you covering your dependents? <input type="checkbox"/> Yes (If yes, please complete the information below)								
	<input type="checkbox"/> No (If no, please complete the Waiver/Declination of Coverage Form)								
	Dependent Name		Relationship to You		Sex	Date of Birth		Social Security Number	
	Last		First		Middle		Mo	Day	Year
	1.								
	2.								
3.									
4.									
5.									
I certify that my date of birth, date of full-time employment and other information on this form is correct and that I am working at the employer's place of business in a full-time capacity of at least 24 hours per week or as mirrors our health plan eligibility. I agree to continue my participation in the program while coverage is in force. I understand that, if enrolled in the DeltaCare Dental plan, you may assign me to a dental provider if I have not indicated my selection above.									
Your Signature in ink				Date: Month Day Year					
FOR OFFICE USE ONLY	Process Date	Processed By:	Effective Date	Dental Group #	Dental Code				

MULTI BENEFIT PLANS
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