

Benefits Staff Signature

SUBMIT FORM TO Benefits Department:

701 N. Madison Street Stockton, CA 95202 Office (209) 933-7026 Fax (209) 933-7011



ALL ELIGIBLE DISTRICT EMPLOYEES (20+ HOURS PER WEEK)

DELTA DENTAL GROUP								
Date:								
☐ 6540-0008 SPPA RETIRED	☐ 6540-0004 SPEC ED, PAR.	A 🗆	6540-0003 SPPA	A	1 65	540-0011	POLICI	E
☐ 6540-0001 BOARD, MGT, CONF, UNREP	☐ 6540-0020 COBRA		J 6540-0004 CSEA 821 □			3 6540-0010 ADULT		
☐ 6540-0002 STA	☐ 6540-0012 USA		6540-0006 CSEA	A 885	1 6:	540-0007	SUSU	
MES Vision Groups								
☐ HMO - 24036	☐ PP	O - 2434	7					
TYPE OF ACTION (Check Boxes That App	oly)							
Effective Date:								
☐ New Hire	☐ Adding Dependent ☐ Change of Cover			Covera	rage			
☐ Retiree	Change of Bargaining Unit		☐ Drop Covera	age (Ci	rcle) Em	ployee/D	epend	ents
☐ Open Enrollment	☐ Enroll - Loss of Coverage							
EMPLOYEE INFORMATION								
Gender: ☐ Male ☐ Female	Marital Status: ☐ Single	e □ Ma	rried, Date of Ma	arriage	(Require	ed):		
Name:	Date of Birth:/							
Social Security#:			Date	e of H	lire:	/	/_	
Address:	City:			State:		_Zip:		
Address: Telephone Number:	•							
Telephone Number:	E-m							
Telephone Number:	E-m	ail (opt	ional):					
Telephone Number:	E-m	ail (opt	ex)					
Telephone Number:	E-m	ail (opt	ex)					
Telephone Number: ONLY LIST DEPENDENT TO BE COVER DEPENDENTS (Check One)	E-m RED UNDER PLAN se	ail (opt	ex)				GEN	DER
Telephone Number:	E-m RED UNDER PLAN se	ail (opt (Same S DATE C	ex) OF BIRTH	SOCIA	IL SECU		GEN	DER M
Telephone Number: ONLY LIST DEPENDENT TO BE COVER DEPENDENTS (Check One)	E-m RED UNDER PLAN Se	ail (opt (Same S DATE C	ex) PF BIRTH	SOCIA	L SECU	RITY#	GEN F	DER M
Telephone Number: ONLY LIST DEPENDENT TO BE COVER DEPENDENTS (Check One)	E-m RED UNDER PLAN Se	ail (opt (Same S DATE C	ex) PF BIRTH	SOCIA	L SECU DISABI Y	RITY# LED DEP	GEN F	DER M
Telephone Number:	E-m RED UNDER PLAN Se	ail (opt (Same S DATE C	ex) PF BIRTH	SOCIA	L SECU	RITY#	GEN F GEN F	IDER M IDER M

Date