Medical/Dental/Vision Enrollment Form

Delta Dental PPO Plan with Point of Service (POS)
Group #2491

Choose One Empire Blue Cross: ☐ **EPO** ☐ **PPO**
Group # 720430 **EPO: 01-03-05** **PPO: 02-04-06**
Coverage: ☐ **Individual** ☐ **2 Person** ☐ **Family**

Specify Bargaining Unit _____

Davis Vision

☐ **Full Time - Probationary/Perm** ☐ **Part-Time - Dates:** _____ ☐ **Replacement - Dates:** _____

☐ **Retired/Under 65** ☐ **Retired/Over 65**

1. Participant Information: **Enrollment Date:**

Last Name	First Name	Initial	Social Security Number	
Street Address		County		
City	State	Zip Code	Home Telephone Number	Daytime Telephone Number
☐ Female ☐ Male	Date of Birth	Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed		
Do you, your spouse or dependents have other medical insurance that will be maintained in addition to Blue Cross? ☐ Individual ☐ 2 Person ☐ Family Name of Spouse's Carrier _____ Coverage Start Date _____		Are you currently enrolled in Medicare? If so, please check all that apply: Employee: ☐ Part A ☐ Part B Medicare # _____ Part A Hospital Start Date _____ Part B Medical Start Date _____ Spouse: ☐ Part A ☐ Part B Medicare # _____ Part A Hospital Start Date _____ Part B Medical Start Date _____		

2. Information for ALL Eligible Dependents to be Enrolled

Last Name (if different)	First Name	Social Security #	Date of Birth	Relationship to Employee	Check if Dependent is Over 18	Check if Dependent is Disabled
				Spouse	N/A	
				☐ Son ☐ Daughter		
				☐ Son ☐ Daughter		
				☐ Son ☐ Daughter		
				☐ Son ☐ Daughter		

3. Please Sign:

Employee's Signature _____ **Date** _____

Group Benefits Authorizing Signature: _____ **Date** _____ **Effective Date of Coverage** _____