SUBMIT FORM TO: Benefits Department
56 South Lincoln Street • Stockton, CA 95203
Office (209) 933-7026
Fax (209) 933-7011
Email: benefits@stocktonusd.net

SISC III
SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

DELTA DENTAL PPO GROUP

Date: _____

❒ 6540-0004 SPEC ED, PARA ❒ 6540-0004 CSEA 821 ❒ 6540-0003 SPPA ❒ 6540-0011 POLICE

❒ 6540-0001 BOARD, MGT, CONF, UNREP ❒ 6540-0020 RETIREE ❒ 6540-0012 USA ❒ 6540-0010 ADULT

❒ 6540-0002 STA ❒ 6540-0008 SPPA RETIREE ❒ 6540-0006 CSEA 885 ❒ 6540-0007 SUSU

EyeMed Vision Groups

❒ HMO (Hardware only) - 1036708 ❒ PPO (Exam & Hardware) - 1039288

TYPE OF ACTION *(Check Boxes That Apply)*

Effective Date: _____

❒ New Hire ❒ Adding Dependent ❒ Change of Coverage

❒ Retiree ❒ Change of Bargaining Unit ❒ Drop Coverage (Circle) Employee/Dependents

❒ Open Enrollment ❒ Enroll - Loss of Coverage

EMPLOYEE INFORMATION

Gender: ❒ Male ❒ Female Marital Status: ❒ Single ❒ Married/DP, Date of Marriage/DP *(Required)*: _____

Name: _____ Date of Birth: _____/_____/_____

Social Security#: _____ Date of Hire: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____ E-mail (optional): _____

ONLY LIST DEPENDENT TO BE COVERED UNDER PLAN

DEPENDENTS *(Check One)* ❒ **Spouse** ❒ **Domestic Partner**

NAME	DATE OF BIRTH	SOCIAL SECURITY #	GENDER
			F ☐ M ☐

CHILDREN *(List All Eligible Dependent Children)*

NAME	DATE OF BIRTH	SOCIAL SECURITY #	DISABLED DEP	GENDER
			Y ☐ N ☐	F ☐ M ☐
			Y ☐ N ☐	F ☐ M ☐
			Y ☐ N ☐	F ☐ M ☐
			Y ☐ N ☐	F ☐ M ☐

_____ _____
Employee Signature *(Form must be signed to be processed)* Date

_____ _____
Benefits Staff Signature Date