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

DELTA DENTAL PPO GROUP

Date: ________________

❐ 6540-0004 SPEC ED, PARA ❐ 6540-0004 CSEA 821 ❐ 6540-0003 SPPA ❐ 6540-0011 POLICE ❐ 6540-0002 STA

❐ 6540-0001 BOARD, MGT, CONF ❐ 6540-0006 CSEA 885 ❐ 6540-0012 USA ❐ 6540-0010 NUHW ❐ 6540-0007 SUSU

EyeMed Vision Groups

❐ HMO (Hardware only) - 1036708 - ______ ❐ PPO (Exam & Hardware) - 103928 - ______

SPEC ED, PARA - 1004 CSEA 821 - 1004 SPPA - 1003 POLICE - 1009 STA - 1002
BOARD, MGT, CONF - 1001 CSEA 885 - 1005 USA - 1010 NUHW - 1008 SUSU - 1006

TYPE OF ACTION *(Check Boxes That Apply)*

Effective Date: ________________

❐ New Hire ❐ Adding Dependent(s) ❐ Change of Coverage
❐ Return from LOA ❐ 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