CONTRA COSTA COUNTY
Office of Education
learn • lead • achieve

Delta Dental & VSP Vision Care Plans

Enrollment Form

Group Name: Contra Costa County Office of Education

A ENROLLEE (Complete this section for new enrollment or change of status)

Name	Social Security Number	Action Requested
_____ Last First Middle Initial	_____-_____-_____ (Member I.D. Number	❒ New enrollment ❒ COBRA enrollment ❒ Change in enrollment ❒ Reinstatement

Birthdate	Sex	Classification	Mailing Address	Telephone Number
_____/_____/_____ Month Day Year	❒ Male ❒ Female	❒ Certificated ❒ Classified ❒ CDC ❒ COBRA	_____ Street number or PO box _____ City, State, Zip	( )

❒ **COBRA Enrollment -** I understand that I will be required to pay for COBRA benefits

Note: If Dependent is enrolling under own social security number, the original Member's social security number must be supplied

_____ Benefits previously received under Social Security Number (Member I.D. Number)

Qualifying Date _____/_____/_____ Month Day Year

B Change to Existing Enrollment (Complete all sections that apply)

❒ Name Change ❒ Add new dependent ❒ Delete Dependent ❒ Open Enrollment

Reason for change _____ Effective date of change _____/_____/ Month Day

C DEPENDENTS (Complete for new enrollment or to add or delete dependents)

Spouse Name Last (if different) First Middle Initial	Dental(D) VSP (V) or both (B)	Add/ Delete	Sex M F	Birthdate Month/Day/Year _____/_____/_____	Spouse's Social Security #	Marriage/Divorce Date Month/Day/Year _____/_____/_____
Child Name Last (if different) First Middle Initial		**Add/ Delete**	**Sex** M F	**Birthdate** Month/Day/Year	**Child's** Social Security #	**CCCOE Use Only**
						_____ Coverage Level _____ Effective Date of Coverage

D Signature (Form must be signed to be processed)

I understand that I may be required by the employer to pay for these benefits. I agree to comply with the terms of the group contract.

Employee Signature _____ **Date** _____