CalCPA Health

Delta Dental / Vision Service Plan Enrollment Form
Group Insurance Trust of the California Society of Certified Public Accountants

I. COVERAGE(S): Please check only the plan(s) in which your employer is enrolled.

D **Delta Dental** D **Vision Service Plan**

Please Note: both the dental and vision plans require 100% participation of all employees unless covered by another group plan.

II. ENROLLEE

Last Name (Print)	First	MI

Mailing Address	City	State	ZIP

Home Phone No.	Work Phone No.	Date of Birth (mm/dd/yy)	Social Security No.	Date of Hire/Rehire (mm/dd/yy)
( )	( )			

Employer	Occupation	Society Membership No.	D Male D Female D Single D Married D Divorced

Does your spouse have a dental and/or vision plan? D Yes D No If yes, who is covered? D Yourself D Spouse/Domestic Partner D Dependent(s)

Check this box only if you are declining coverage, provide evidence of your enrollment in another group plan and sign below.

D I decline this coverage because I am covered by another group plan. *Do not sign here unless you are declining coverage.*

Signature: _____ Date: _____

III. DEPENDENTS

D **Spouse** D **Domestic Partner** (Please check one)

First	MI	Last	Social Security #	D Male D Female	Date of Birth	

Child(ren)

	First	MI	Last (if different)	Social Security #	D Male D Female	Date of Birth	If child is 19 or over (please check one)
1					D Male D Female		D Full-Time Student D Disabled
2					D Male D Female		D Full-Time Student D Disabled
3					D Male D Female		D Full-Time Student D Disabled
4					D Male D Female		D Full-Time Student D Disabled

IV. SIGNATURE

_____ _____

Employee's Signature Date

Please return the completed form to:

Banyan Administrators, LLC – Managers
for the CalCPA Health Programs
1215 Manor Drive, Suite 200
Mechanicsburg, PA 17055
or fax to: (877) 237-4519

If you have any questions, please contact us toll-free at (877) 480-7923