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.

☐ **Delta Dental** ☐ **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.	☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced	

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

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

☐ 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

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

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

Child(ren)

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

IV. SIGNATURE

_________________________________ _________________

Employee's Signature Date

Please return the completed form to:

Banyan Administrators, LLC –
Managers for the CalCPA ProtectPlus 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