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		Date of Birth	
			❑ Male ❑ Female		

Child(ren)

	First	MI	Last (if different)		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:

Seabury & Smith
ATTN: CPA Unit
One California Street, 8th Floor
San Francisco, CA 94111

Or Fax to:
1-800-682-8787

If you have any questions, please contact us toll-free at 1-800-824-1154.