DELTA HEALTH SYSTEMS

HEALTH PLAN ENROLLMENT CARD

P.O. Box 1147 • Stockton, CA 95201-1147
Phone 209-948-8483 • 800-422-6099

EMPLOYEE NAME	LAST	FIRST	INITIAL	SOCIAL SECURITY NO.
ADDRESS	CITY	STATE	ZIP	BIRTHDATE MO. / DAY / YR.
DAYTIME PHONE NUMBER	EVENING PHONE NUMBER	EMAIL ADDRESS		
MALE ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐ FEMALE ☐ MARRIED ☐ SEPARATED ☐	EMPLOYER NAME	DATE OF HIRE MO. / DAY / YR.	EFFECTIVE DATE MO. / DAY / YR.	
LIFE INSURANCE BENEFICIARY		RELATIONSHIP		

PLEASE LIST DEPENDENTS TO BE COVERED		DATE OF BIRTH	IF DEPENDENT HAS OTHER	NAME OF EMPLOYER OR
RELATIONSHIP	PROVIDE FULL NAME OF DEPENDENTS	SOCIAL SECURITY #	HEALTH COVERAGE, INDICATE NAME OF CARRIER	COLLEGE, IF APPLICABLE
A copy of your marriage license is required.				
HUSBAND ☐ WIFE ☐	LAST NAME FIRST INITIAL	BIRTHDATE: SS#	☐ YES ☐ NO NAME OF CARRIER	
A copy of your child's birth certificate(s) is required.				
SON ☐ DAUGHTER ☐ STEP-CHILD ☐	LAST NAME FIRST INITIAL	BIRTHDATE: SS#	☐ YES ☐ NO NAME OF CARRIER	
SON ☐ DAUGHTER ☐ STEP-CHILD ☐	LAST NAME FIRST INITIAL	BIRTHDATE: SS#	☐ YES ☐ NO NAME OF CARRIER	
SON ☐ DAUGHTER ☐ STEP-CHILD ☐	LAST NAME FIRST INITIAL	BIRTHDATE: SS#	☐ YES ☐ NO NAME OF CARRIER	
SON ☐ DAUGHTER ☐ STEP-CHILD ☐	LAST NAME FIRST INITIAL	BIRTHDATE: SS#	☐ YES ☐ NO NAME OF CARRIER	
SON ☐ DAUGHTER ☐ STEP-CHILD ☐	LAST NAME FIRST INITIAL	BIRTHDATE: SS#	☐ YES ☐ NO NAME OF CARRIER	

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance company, employer, union or group policyholder to furnish to Delta Health Systems, its agents or representatives any and all records or information pertaining to eligibility, medical history, treatment, diagnosis and prognosis with respect to me, my spouse, or my children who are included under my coverage for purposes of review, investigation, or evaluation of a claim.

I AUTHORIZE Delta Health Systems, its agents or representatives to disclose any information obtained to an insurance company, reinsurance carrier, group policyholder, or other persons or organizations performing direct administrative, professional, medical or legal services in connection with my claim.

I UNDERSTAND the information obtained by use of this Authorization will be used by Delta Health Systems to determine eligibility for benefits and for the purpose of reviewing health care services with respect to medical necessity, level of care, quality of care, or justification of charges.

I UNDERSTAND that I am entitled to a copy of this signed authorization if I request it, and certify by signature that information contained herein is true and correct.

I approve the above authorization and make application for membership for myself and my eligible family members and authorize my employer to make the necessary deduction, if any, from my wages or salary for the contributions required of me for this coverage. I certify the information contained herein is true and correct, and all dependents meet the eligibility requirements of the Plan. I further state that I will notify Delta Health Systems if my dependents' eligibility status changes.

SIGNATURE ____________________ DATE ____________________