SISC III
SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

DENTAL / VISION ENROLLMENT FORM

DENTAL GROUP NO.
7075-5400
EFFECTIVE DATE
1 0 0 1 1 1

Delta Dental Premier PPO/Vision Service Plan

District Name: Santa Barbara Unified School District

Member Name:

Member Address:

DENTAL ENROLLMENT

___Employee Only ___Employee + 1 Dep. ___Employee + Family

Complete information below if you wish to enroll in dental.

	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	QUALIFIES AS IRS DEPENDENT	FULL-TIME STUIDENT	DATE OF BIRTH	AGE
Employee								
☐ Spouse ☐ Domestic Partner					☐ YES ☐ NO	☐ YES ☐ NO		
☐ SON ☐ DAUGHTER					☐ YES ☐ NO	☐ YES ☐ NO		
☐ SON ☐ DAUGHTER					☐ YES ☐ NO	☐ YES ☐ NO		
☐ SON ☐ DAUGHTER					☐ YES ☐ NO	☐ YES ☐ NO		
☐ SON ☐ DAUGHTER					☐ YES ☐ NO	☐ YES ☐ NO		
☐ SON ☐ DAUGHTER					☐ YES ☐ NO	☐ YES ☐ NO		

VISION GROUP NO.
2465606A
EFFECTIVE DATE
1 0 0 1 1 1

VISION ENROLLMENT

___Employee Only ___Employee + 1 Dep. ___Employee + Family

Complete information below if you wish to enroll in vision.

	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	QUALIFIES AS IRS DEPENDENT	FULL-TIME STUIDENT	DATE OF BIRTH	AGE
EMPLOYEE								
☐ Spouse ☐ Domestic Partner					☐ YES ☐ NO	☐ YES ☐ NO		
☐ SON ☐ DAUGHTER					☐ YES ☐ NO	☐ YES ☐ NO		
☐ SON ☐ DAUGHTER					☐ YES ☐ NO	☐ YES ☐ NO		
☐ SON ☐ DAUGHTER					☐ YES ☐ NO	☐ YES ☐ NO		
☐ SON ☐ DAUGHTER					☐ YES ☐ NO	☐ YES ☐ NO		
☐ SON ☐ DAUGHTER					☐ YES ☐ NO	☐ YES ☐ NO		

SIGNATURE: _____ **DATE:** _____