Mail to:
P.O. Box 23700
Newark, NJ 07189-0001
(973) 285-4144

DENTAL ENROLLMENT FORM

○ **Eight Digit Group Number**

○ 7009-0001

Name of Employer	Effective Date of Coverage

GENERAL INFORMATION - THIS SECTION MUST BE COMPLETED - PLEASE PRINT CLEARLY

Name (Last) (First) (Middle)	Date of Birth	Social Security Number
	_____ / _____ / _____	___ ___ ___ - ___ ___ - ___ ___ ___ ___

Street Address	City, State, Zip	County

Date of Employment	Type of Coverage	Marital Status	Home Telephone
_____ / _____ / _____	☐ Single ☐ Parent/Child ☐ Husband/Wife ☐ Parent/Children ☐ Family	☐ Single ☐ Married ☐ Divorced/Separated	( )

Enrollment	First Name - Last Name	Social Security Number	Date of Birth	Full-Time Student
Subscriber		_____ - _____ - _____	/ /	
Spouse*		_____ - _____ - _____	/ /	
Dependent		_____ - _____ - _____	/ /	☐ Yes ☐ No
Dependent		_____ - _____ - _____	/ /	☐ Yes ☐ No
Dependent		_____ - _____ - _____	/ /	☐ Yes ☐ No

* If spouse has other dental coverage, please list name and address of employer and other carrier:

If choosing DeltaCare, you must complete this section

	Choice of Dentist	Office Number	For Delta Use Only
1			
2			
3			

I hereby represent that all information furnished is true and complete to the best of my knowledge and authorize my employer to make any required deduction from my wages.

_____ _____
Subscriber Signature Date

Delta Use Only

_____
Entered

_____
Operator #