DELTA DENTAL

Delta Dental PPO℠ plus Premier

DENTAL ENROLLMENT FORM

Group Number

04730- _ _ _ _

Name of Group	Effective Date of Coverage	
Granby Board of Education	**07/01/2019**	**Position:** _____

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
Dependent			/ /	☐ Yes ☐ No

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

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 #