Mail to:
Delta Dental of New Jersey
P.O. Box 23700
Newark, NJ 07189
(973) 285-4144

DENTAL ENROLLMENT FORM

Delta Dental PPO plus Premier

Eight Digit Group Number

4674 - _ _ _ _

	Full Plan	Flex Plan
Actives	0001	0011
Cobra	0002	0022
Retiree <65	0003	0033
Housing Authority	0004	0044
Housing Authority Cobra	0005	0055
House Authority Retiree <65	0006	0066

Name of Employer

Glastonbury, Town of

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
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 #