Delta Dental Plan of New Jersey

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

DENTAL ENROLLMENT FORM

Eight Digit Group Number

☐ Premier 7369

Name of Employer	Effective Date of Coverage
SOMERVILLE BOARD OF EDUCATION	

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 #