

DENTAL ENROLLMENT FORM

Eight Digit Group Number

Name of Employer

**Bridgewater-Raritan Regional
Board of Education**

Effective Date of Coverage

☐ Delta Dental Premier®/Advantage

Program/Delta PPO 07668 - _____

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
☐ Husband/Wife
☐ Family

☐ Parent/Child
☐ Parent/Children

☐ Single
☐ Married
☐ Divorced/Separated

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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 #