DELTA DENTAL

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

DENTAL ENROLLMENT FORM

Group Number

Delta Dental Premier

4231

Name of Employer	Effective Date of Coverage
East Windsor Town & Board of Education	

- ☐ 0020 Board of Education
- ☐ 0010 Town Police
- ☐ 0016 Town WPCA, Treasurers Office
- ☐ 0034 Town Hall Clerical
- ☐ 0008 Town Hall Union

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 ☐ Civil Union	☐ Single ☐ Married ☐ Divorced/Separated	( )

Enrollment	First Name - Last Name	Social Security Number	Date of Birth	Full-Time Student**
Subscriber		___-___-___	/ /	
Spouse*			/ /	
Dependent			/ /	
Dependent			/ /	
Dependent			/ /	
Dependent			/ /	

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

**Where dependent coverage terminates at age 19, it may be extended to age 25, if the dependent is full time student in an accredited school, college or university.

Please complete "Student Affidavit" and attach to your enrollment form.

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 # _____