DELTA DENTAL ENROLLMENT FORM

Delta Premier

Eight Digit Group Number

7283-0001

Name of Employer	Effective Date of Coverage
JEFFERSON TOWNSHIP BOE	_____/_____/_____

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	Enrollment Change Reque

Date of Employment	Type of Coverage	Marital Status	Home Telephone
____/____/____	☐ Single ☐ Husband/Wife ☐ Family ☐ Parent/Child ☐ Parent/Children ☐ Opt out	☐ Single ☐ Married ☐ Divorced/Separated	( )

Enrollment	First Name - Last Name	Social Security Number	Date of Birth	Full-Time Student
Subscriber		_____-_____-_____	/ /	
Spouse* Add		_____-_____-_____	/ /	
Dependent Add		_____-_____-_____	/ /	☐ Yes ☐ No
Dependent Add		_____-_____-_____	/ /	☐ Yes ☐ No
Dependent Add		_____-_____-_____	/ /	☐ Yes ☐ No
Dependent Add		_____-_____-_____	/ /	☐ Yes ☐ No

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

Special Remarks:

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

Office Use Only

_____

Entered

_____

Employer Signature