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** ☐ **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 #