DENTAL ENROLLMENT FORM

Eight Digit Group Number

☐ Delta Dental Premier®/Advantage Program 7260 - 0001

Name of Employer	Effective Date of Coverage
SUSSEX WANTAGE REGIONAL 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 #