

Enrollment/ Change Form



Delta Dental of New Jersey, Inc
Email: eliginquiry@deltadentalnj.com

Please check the applicable box or boxes.

- | | |
|---|---|
| ☐ New enrollment | ☐ Address change |
| ☐ Change of dependents | ☐ Coverage change |
| ☐ Termination | ☐ Name change |
| ☐ Decline Coverage | ☐ Continuation of Coverage |

Please check the applicable box or boxes.

- ☐ Delta Dental PPO
☐ Delta Dental PPO plus Premier
☐

Delta Dental of New Jersey, Inc.

Primary Enrollee Social Security Number	Last Name	First Name	MI	Date of Birth	Gender ☐ Male ☐ Female
Alternate Identification Number (if applicable)	Address (Is this a change of address?) ☐ Yes ☐ No	Street	City	State	Zip Code
	Email Address:				

Group Number	Sublocation	Group Name
--------------	-------------	------------

Change of Coverage		Continuation of Coverage	
New Coverage:	Former Coverage:	Coverage For	☐ Employee ☐ Dependents
Name Change		Length of Continuation	☐ 18 Months ☐ 36 Months
From:	To:	Date of Loss of Coverage	Date of Qualifying Event
Dependent Change Please check one of the boxes: ☐ Add dependent(s) listed below ☐ Delete dependent(s) listed below			

Do you or your dependents have other dental coverage? ☐ Yes ☐ No <i>If yes, please complete the following:</i>	Carrier Name and Address:
	Group Number:

Last name (if different)	First Name	MI	Gender	Date of Birth	Social Security Number
Spouse / Domestic Partner (if coverage applies)			☐ M ☐ F		
Children			☐ M ☐ F		
			☐ M ☐ F		
			☐ M ☐ F		
			☐ M ☐ F		
			☐ M ☐ F		

Date of Hire:	Effective Date:	Primary Enrollee Signature:	Date
Employer Verification - To Be Completed by Employer The requested activity is believed eligible and is approved		Employer Signature	Title
			Date

Any person who includes any false or misleading information on an application for dental benefits is subject to criminal and civil penalties.
The dental benefits contract does not include coverage of pediatric dental services that meet requirements of the federal Patient Protection and Affordable Care Act.

RESET