DELTA DENTAL®

DENTAL ENROLLMENT FORM

03080

☐ Delta Dental Premier® Program (Clerical)
03080-00001

☐ Delta Dental Premier® Program (Dept Heads)
03080-00002

☐ Delta Dental Premier® Program (DPW)
03080-00003

☐ Delta Dental Premier® Inventive Program (PBA)
03283-00004

Name of Employer

Township of Jackson

Effective Date of Coverage

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 Dental Use Only
_____
Entered
_____
Operator #

Claims Mailing address – PO Box 222 Parsippany, NJ 07054
Customer Serv. number – (800) 452-9310
Web Site – www.deltadentalnj.com