DELTA DENTAL ENROLLMENT FORM

Eight Digit Group Number

Name of Employer	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 Use Only

_________________ Entered

_________________ Operator #