Mail to:
Delta Dental of New Jersey
P.O. Box 23700
Newark, NJ 07189
(973) 285-4144

DENTAL ENROLLMENT FORM

Delta Dental PPO plus Premier

Eight Digit Group Number

4655

(To be completed by employer)

- 0014 Fire
- 0015 MEU
- 0051 Supervisors
- 0213 Non Union
- 0215 Police
- 0240 PW Parks/Rec
- 0001 Cobra

Name of Employer	Effective Date of Coverage
Town of East Hartford	

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 #