DENTAL ENROLLMENT FORM

Group Number

4731 - _ _ _ _

(to be completed by group)

Town		
☐	1000	Full Dental A Actives
☐	1100	Copay A Actives
☐	1001	Full Dental A COBRA
☐	1101	Copay A COBRA
Board of Education		
	2000	Full Dental Actives
/ ☐	2100	Copay Dental A Actives
☐	2001	Full Dental COBRA
☐	2101	Copay Dental A COBRA

Name of Group	Effective Date of Coverage
Town of Plainville	____/____/____

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 # ____________