DELTA DENTAL

DENTAL ENROLLMENT FORM

Group Number

4731 - _ _ _ _

(to be completed by group)

Town		
☐	1000	Full Dental A Actives
☐	1001	Full Dental 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 #