

Enrollment/ Change Form



Delta Dental of New Jersey, Inc
1639 Route 10
Parsippany, NJ 07054
800-624-2633

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|---|---|---|
| <p><i>Please check the applicable box or boxes.</i></p> <input type="checkbox"/> New enrollment <input type="checkbox"/> Address change <input type="checkbox"/> Change of dependents <input type="checkbox"/> Coverage change <input type="checkbox"/> Termination <input type="checkbox"/> Name change <input type="checkbox"/> Decline Coverage <input type="checkbox"/> Continuation of Coverage | <p><i>Please check the applicable box or boxes.</i></p> <p>Delta Dental PPOSM Delta Dental PPOSM plus Premier EHB</p> | <p>Delta Dental of New Jersey, Inc.</p> |
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|---|--|------------|------|---------------|---|
| Primary Enrollee Social Security Number | Last Name | First Name | MI | Date of Birth | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Alternate Identification Number (if applicable) | Address (Is this a change of address?) <input type="checkbox"/> Yes <input type="checkbox"/> No | Street | City | | State |
| | Email Address: | | | | |

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|--------------|-------------|------------|
| Group Number | Sublocation | Group Name |
|--------------|-------------|------------|

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| <p>Change of Coverage</p> <p>New Coverage: _____ Former Coverage: _____</p> | <p>Continuation of Coverage</p> <p>Coverage For <input type="checkbox"/> Employee <input type="checkbox"/> Dependents</p> <p>Length of Continuation <input type="checkbox"/> 18 Months <input type="checkbox"/> 36 Months</p> |
| <p>Name Change</p> <p>From: _____ To: _____</p> | |

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|---|--------------------------|--------------------------|
| <p>Dependent Change Please check one of the boxes:</p> <input type="checkbox"/> Add dependent(s) listed below <input type="checkbox"/> Delete dependent(s) listed below | Date of Loss of Coverage | Date of Qualifying Event |
|---|--------------------------|--------------------------|

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| Do you or your dependents have other dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please complete the following:</i> | Carrier Name and Address: Group Number: |
|--|--|

| Last name (if different) | First Name | MI | Gender | Date of Birth | Social Security Number |
|---|------------|----|---|---------------|------------------------|
| Spouse / Domestic Partner (if coverage applies) | | | <input type="checkbox"/> M <input type="checkbox"/> F | | |
| Children | | | <input type="checkbox"/> M <input type="checkbox"/> F | | |
| | | | <input type="checkbox"/> M <input type="checkbox"/> F | | |
| | | | <input type="checkbox"/> M <input type="checkbox"/> F | | |
| | | | <input type="checkbox"/> M <input type="checkbox"/> F | | |
| | | | <input type="checkbox"/> M <input type="checkbox"/> F | | |

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|---------------|-----------------|-----------------------------|------|
| Date of Hire: | Effective Date: | Primary Enrollee Signature: | Date |
|---------------|-----------------|-----------------------------|------|

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|--|--------------------|-------|------|
| <p>Employer Verification - To Be Completed by Employer</p> <p>The requested activity is believed eligible and is approved</p> | Employer Signature | Title | Date |
|--|--------------------|-------|------|

Any person who includes any false or misleading information on an application for dental benefits is subject to criminal and civil penalties.
The dental benefits contract does not include coverage of pediatric dental services that meet requirements of the federal Patient Protection and Affordable Care Act.