

Enrollment/ Change Form



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

Please check the applicable box or boxes.

- New enrollment
- Change of dependents
- Termination
- Decline Coverage
- Address change
- Coverage change
- Name change
- Continuation of Coverage

Please check the applicable box or boxes.

- Delta Dental PPO™
- Delta Dental PPO plus Premier™
- EHB

Delta Dental of New Jersey, Inc.

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

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|--|--------------------------|--|--------------------------|
| Dependent Change Please check one of the boxes: <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 | | |

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

| | | | |
|---|--------------------|-------|------|
| Employer Verification - To Be Completed by Employer The requested activity is believed eligible and is approved | 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.