DENTAL ENROLLMENT FORM

Delta Dental PPO℠ plus Premier

Group Number

4964- _ _ _ _

(To be completed by group)

______ Teachers 4694-03

______ Non-Teachers 4694-04

Name of Group	Effective Date of Coverage
Naugatuck Board of Education	______ / ______ / ______

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 #