Enrollment/ Change Form

DELTA DENTAL®

Delta Dental of New Jersey, Inc.
Delta Dental of Connecticut, Inc.
P.O. Box 16354
Little Rock, AR 72231
(800) 452-9310 Fax: (973) 285-4142

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.

	Subgroup #	*Plan Name*
☐	_____	**Delta Dental PPO™**
☐	_____	**Delta Dental PPO™ Plus Premier**
☐	_____	**DeltaVision®**

Dental: Underwritten by Delta Dental of Connecticut, Inc. and administered by Delta Dental of New Jersey, Inc.

Vision: Underwritten by Delta Dental of Connecticut, Inc. and administered by Vision Service Plan Insurance Company ("VSP®")

Primary enrollee Social Security Number	Last name	First name	MI	Date of birth	Gender ☐ Male ☐ Female
Alternate identification number (if applicable)	Address (Is this a change of address?) ☐ Yes ☐ No	Street	City	State	Zip code
		Email address:			

Group number	**Group Name**

Change of coverage

New coverage:		Former coverage:	

Name change

From:		To:	

Dependent change Please check one of the boxes:
☐ Add dependent(s) listed below ☐ Delete dependent(s) listed below

Continuation of coverage

Coverage for ☐ Employee ☐ Dependents

Length of continuation ☐ 18 Months ☐ 36 Months

Date of loss of coverage		Date of qualifying event	

Do you or your dependents have other dental or vision coverage? ☐ Yes ☐ No *If yes, please complete the following:*

Carrier name and address:	
Group number:	

Last name (if different)	First name	MI	Coverage	Gender	Date of birth	Social Security Number
Spouse / Domestic Partner (if coverage applies)			☐ Dental ☐ Vision	☐ M ☐ F		
Children			☐ Dental ☐ Vision	☐ M ☐ F		
			☐ Dental ☐ Vision	☐ M ☐ F		
			☐ Dental ☐ Vision	☐ M ☐ F		
			☐ Dental ☐ Vision	☐ M ☐ 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 knowingly and with intent to defraud any insurance company or any other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

This contract does not include coverage of pediatric dental or vision services that meet requirements of the federal Patient Protection and Affordable Care Act.

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