# DENTAL ENROLLMENT FORM

**Please select plan:**

☐ Delta Dental Premier® 07477-00001
☐ Delta Dental PPO™ 07477-06001
☐ Flagship NJ7 07477-00001

| Name of Employer | Effective Date of Coverage |
|---|---|
| **Essex Regional Educational Services Commission** | |

**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<br>☐ Husband/Wife ☐ Parent/Children<br>☐ Family | ☐ Single<br>☐ Married<br>☐ 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:**

**If choosing Flagship, you must complete this section**

| | Choice of Dentist | Office Number | For Delta Dental Use Only |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |

**Optional choices will be selected if a provider terminates his/her participation agreement with Flagship. I authorize the release to Flagship Dental Plans of all my treatment information as a DeltaCare® subscriber and the treatment information of my dependent(s). I understand that I may change my primary Plan Participating Dentist by calling or in writing provided that a request for such change is received by Flagship at least thirty (30) days prior to the new contract month. Request received by the tenth (10th) of the month will be effective the first (1st) of the following month.**

**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 Dental Use Only**

_____
**Entered**

_____
**Operator #**

eliginquiry@deltadentalnj.com