DENTAL ENROLLMENT FORM

Eight Digit Group Number

☑ Delta Dental Premier® 07696 -00089

☐ Delta Dental Premier® 07696- 00489

☐ Delta Dental Premier® 07696 - 00589

Name of Employer	Effective Date of Coverage
Pleasantville Board of Education Group # 07696	

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 Dental Use Only

_____

Entered

_____

Operator #