

Enrollment/ Change Form



Delta Dental of New Jersey
 P.O. Box 16354
 Little Rock, AR 72231
 Email: eliginquiry@deltadentalnj.com

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 PPOSM
- Delta Dental PPOSM plus Premier
- EHB

Delta Dental of New Jersey, Inc.

Primary Enrollee Social Security Number	Last Name	First Name	MI	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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Alternate Identification Number (if applicable)	Address (Is this a change of address?) <input type="checkbox"/> Yes <input type="checkbox"/> No	Street	City	State	Zip Code
		Email Address:			

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"/>	

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:
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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
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Employer Verification - To Be Completed by Employer The requested activity is believed eligible and is approved	Employer Signature	Title	Date
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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.