DELTA DENTAL®

Coordination of Benefits

Submit this form if you or a family member are covered by more than one dental benefits plan. This will ensure that all plans that provide your benefits pay the correct amount toward your claims.

Please provide the following about your Delta Dental of New Jersey/Delta Dental of Connecticut benefits plan:

Member name:	Member date of birth:	Delta Dental ID #:
Member phone number:	Employer name:	Delta Dental group #:

Please provide the following about your other dental benefits plan:

Member name:	Member date of birth:	Relationship to member above:
Carrier name:	Effective date of coverage:	Member ID number:

Dependent(s) covered under your other dental benefits plan:

Name:	Date of birth:
Name:	Date of birth:
Name:	Date of birth:
Name:	Date of birth:

Signature _____ Date _____

Once completed, please return to Delta Dental.

Mail:
Delta Dental of New Jersey
P.O. 16354
Little Rock, AR 77231

Fax:
973-944-4543

Questions? Please call Customer Service at **800-452-9310.**
Monday-Thursday, 8:00 a.m.–6:30 p.m. ET
Friday 8:00 a.m.–5:00 p.m. ET

06/2021
Delta Dental of New Jersey, Inc.
Delta Dental of Connecticut, Inc.