DELTA DENTAL

Delta Dental of New Jersey, Inc.
Coordination of Benefits Form
P.O. Box 222, Parsippany, NJ 07054
Phone: 1-800-452-9310; Fax: 973-285-4141
Email: service@deltadentalnj.com

Dear Member:

If your family has another dental insurance or medical coverage, Delta Dental of New Jersey may be the secondary payer. In order to maintain accurate records and process claims correctly we ask that you complete the following form and return it to Delta Dental of New Jersey at the address noted above. Please send to the attention of the Correspondence Department.

Member Name: ______________________ **Member Policy Number:** ______________________

Other Policy
Group Holder's name(s) ______________________
Date of Birth (Month/Day/Year) ______________________

PLEASE INDICATE CURRENT PRIMARY COVERAGE STATUS BELOW:

Dental:

☐ My dependent(s), ______________________ is not covered by another group dental plan, effective
/ / / Delta Dental of New Jersey is our only dental insurance coverage.

☐ My dependent(s), ______________________ currently has another group dental plan coverage effective
/ / / with the following dental plan ______________________

Policy/Group Number ______________________ Phone Number: ______________________

Medical:

☐ My dependent(s), ______________________ currently has medical insurance coverage effective
/ / / with the following carrier(s) ______________________

Policy/Group Number ______________________ Phone Number: ______________________

Name of policy holder: ______________________ Relationship: ______________________

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Additional dependents or comments:

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By signing this form, I certify that all information is complete and accurate:

Member of Dependent Signature: ______________________ Date: ______________________

Thank you for your assistance in keeping your records up to date and accurate.