



RE: Dependent:

Please complete and return this form either by fax to (973) 285-4141 or by mail to: The Customer Service Department Attention: Correspondence.

(I) MEMBER INFORMATION

Member Name: _____ Date of Birth: ____ / ____ / ____

Member ID# (this could be Member Social Security Number): _____

Daytime Phone Number: (____) ____ - ____ Employer Name _____

Delta Dental Assigned Group Number: ____ - ____ Cobra Plan: Yes or No (circle one)

(II) SECONDARY COVERAGE WITH DELTA DENTAL OF NEW JERSEY (if applicable)

Member Name: _____ Date of Birth: ____ / ____ / ____

Member Social Security Number: ____ - ____ - ____

Daytime Phone Number: (____) ____ - ____ Employer Name _____

Delta Dental Assigned Group Number: ____ - ____ Cobra Plan: Yes or No (circle one)

(III) DEPENDENT INFORMATION:

Dependent Name: _____ Date of Birth: ____ / ____ / ____

Dependent's Social Security Number: ____ - ____ - ____

Student Identification Number (if SSN not used): _____

Name of College: _____ College Phone Number: (____) ____ - ____

Undergraduate or Graduate Student: (circle one) Number of Credits: _____

Semester: Fall or Spring (circle one) Year: 20__ __

(IV) SIGNATURES

By signing this form, I attest that all information is complete and accurate. I authorize Delta Dental of New Jersey to contact the college for further verification if necessary. If the above information should change, I will inform Delta Dental of New Jersey immediately.

Primary Member's Name (Print) _____

Primary Member's Signature: _____ Date: ____ / ____ / ____

Secondary Member's Name (Print) _____

Secondary Member's Signature: _____ Date: ____ / ____ / ____