DELTA DENTAL

Delta Dental of New Jersey, Inc.
Coordination of Benefits Form
P.O. Box 16354, Little Rock AR 72231
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: _____

Name of policy holder: _____ Relationship: _____

Additional dependents or comments:

_____

_____

_____

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.