

Enrollment/ Change Form



Delta Dental of New Jersey, Inc.
1639 Route 10
Parsippany, NJ 07054
800-624-2633

Please check the applicable box or boxes.

- ☐ Change of dependents ☐ Coverage change
☐ Termination ☐ Name change
☐ Decline coverage ☐ Continuation of Coverage

Please check the applicable box or boxes.

- ☐ Bronze - Delta Dental PPOSM
☐ Silver - Delta Dental PPOSM
☐ Gold - Delta Dental PPOSM plus Premier

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
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	Continuation of Coverage
New Coverage: <input type="text"/> Former Coverage: <input type="text"/>	Coverage For <input type="checkbox"/> Employee <input type="checkbox"/> Dependents
Name Change	Length of Continuation <input type="checkbox"/> 18 Months <input type="checkbox"/> 36 Months
From: <input type="text"/> To: <input type="text"/>	Date of Loss of Coverage <input type="text"/> Date of Qualifying Event <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	

Do you or your dependents have other dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete the following:	Carrier Name and Address: <input type="text"/>
	Group Number: <input type="text"/>

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		

Date of Hire: <input type="text"/>	Effective Date: <input type="text"/>	Primary Enrollee Signature: <input type="text"/>	Date: <input type="text"/>
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Employer Verification - To Be Completed by Employer The requested activity is believed eligible and is approved	Employer Signature: <input type="text"/>	Title: <input type="text"/>	Date: <input type="text"/>
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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.