DELTA DENTAL ENROLLMENT FORM

Name of Employer	Effective Date of Coverage
East Orange Board of Education	

Please choose one:

Delta Dental PPO Plus Premier™

- ☐ 07186 – 00001
- ☐ 07186 – 00002
- ☐ 07186 – 00003
- ☐ 07186 – 00004
- ☐ 07186 – 00005 Buy-Up Plan
- ☐ 07186 – 00007 CWA

DeltaCare® Flagship NJ 6

- ☐ 07186 – 9006
- ☐ 07186 – 9007
- ☐ 07186 – 9008
- ☐ 07186 – 9009

GENERAL INFORMATION - THIS SECTION MUST BE COMPLETED - PLEASE PRINT CLEARLY

Name (Last) (First) (Middle)	Date of Birth	Social Security Number
	______ / ______ / ______	___ ___ ___ - ___ ___ - ____ ___ ___ ____

Street Address	City, State, Zip	County

Date of Employment	Type of Coverage	Marital Status	Phone & Email
_____ / _____ / _____	☐ Single ☐ Husband/Wife ☐ Family ☐ Parent/Child ☐ Parent/Children	☐ Single ☐ Married ☐ Divorced/Separated	Phone # ( ) Email:

Enrollment	First Name - Last Name	Social Security Number	Date of Birth	Full-Time Student
Subscriber		_______ - _______ - _______	/ /	
Spouse*		_______ - _______ - _______	/ /	
Dependent		_______ - _______ - _______	/ /	☐ Yes ☐ No
Dependent		_______ - _______ - _______	/ /	☐ Yes ☐ No
Dependent		_______ - _______ - _______	/ /	☐ Yes ☐ No
Dependent		_______ - _______ - _______	/ /	☐ Yes ☐ No

* If spouse has other dental coverage, please list name and address of employer and other carrier:

If choosing DeltaCare®, you must complete this section

	Choice of Dentist	Office Number	For Delta Dental Use Only
1			
2			
3			

Optional choices will be selected if a provider terminates his/her participation agreement with Flagship. I authorize the release to Flagship Dental Plans of all my treatment information as a DeltaCare® subscriber and the treatment information of my dependent(s). I understand that I may change my primary Plan Participating Dentist by calling or in writing provided that a request for such change is received by Flagship at least thirty (30) days prior to the new contract month. Request received by the tenth (10th) of the month will be effective the first (1st) of the following month.

I hereby represent that all information furnished is true and complete to the best of my knowledge and authorize my employer to make any required deduction from my wages.

Subscriber Signature ______________________ Date ______________

Delta Dental Use Only

Entered ______________

Operator # ______________

PPO, Premier, Advantage, Flagship: eliginquiry@deltadentalnj.com