DENTAL ENROLLMENT FORM

Delta Dental PPO℠ plus Premier
Group Number

4669

Sublocation Number/Store Location Number

Name of Employer	Effective Date of Coverage
Town of Darien	

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	Email Address
	☐ Single ☐ Parent/Child ☐ Husband/Wife ☐ Parent/Children ☐ Family	☐ Single ☐ Married ☐ Divorced/Separated	 **Home Telephone**

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 also please include any additional dependents:

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 #