DELTA DENTAL

# DENTAL ENROLLMENT FORM

**Group Number**

**4730 - _ _ _ _**

***(to be completed by group)***

| Town | | |
|---|---|---|
| ☐ | 1000 | Active |
| ☐ | 1001 | COBRA |
| ☐ | 1100 | Retirees |
| Board of Education | | |
| ☐ | 2000 | Active |
| ☐ | 2001 | COBRA |
| ☐ | 2100 | Retirees |

**Name of Group**

Town of Granby & Board of Education

**Effective Date of Coverage**

_____ / _____ / _____

## 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<br>☐ Husband/Wife ☐ Parent/Children<br>☐ Family | ☐ Single<br>☐ Married<br>☐ Divorced/Separated | Home Telephone<br>( ) |

| 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:**

**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 Use Only**

_____

**Entered**

_____

**Operator #**