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 ☐ 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:**

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 #