



Mail to: Passaic Board of Education
 Division of Human Resources
 101 Passaic Avenue, P.O. Box 388
 Passaic, NJ 07055-0388

Eight Digit Group Number

Premier 7034 - _____

Premier (Buy-Up) 7034 - _____

DeltaCare 7034 - 9 _____

DENTAL ENROLLMENT FORM

Name of Employer Passaic Board of Education	Effective Date of Coverage 1/1/2016
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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		Home Telephone		
N/A ____/____/____		<input type="checkbox"/> Single <input type="checkbox"/> Parent/Child <input type="checkbox"/> Husband/Wife <input type="checkbox"/> Parent/Children <input type="checkbox"/> Family				<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced/Separated		()		
Enrollment	First Name - Last Name					Social Security Number		Date of Birth		Full-Time Student
Subscriber						____-____-____		/ /		
Spouse*						____-____-____		/ /		
Dependent						____-____-____		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent						____-____-____		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent						____-____-____		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent						____-____-____		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> 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 Use Only
1.			
2.			
3.			

Optional choices will be selected if a provider terminates his/her participation agreement with Flagship. I authorize the release of Flagship Health Systems of all my treatment information as a DeltaCare subscriber and the treatment information of my dependent(s).

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.

<p>_____</p> <p>Subscriber Signature</p>	<p>_____</p> <p>Date</p>	<p>Delta Use Only</p> <p>_____</p> <p>Entered</p> <p>_____</p> <p>Operator #</p>
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