DELTA DENTAL

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

DENTAL ENROLLMENT FORM

Eight Digit Group Number

☐ Premier 7034 - _____

☐ Premier (Buy-Up) 7034 - _____

☐ DeltaCare 7034 - 9_____

Name of Employer	Effective Date of Coverage
Passaic Board of Education	

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 ____ / ____ / ____	☐ Single ☐ Parent/Child ☐ Husband/Wife ☐ Parent/Children ☐ Family	☐ Single ☐ Married ☐ Divorced/Separated	( )

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 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.

_____ _____
Subscriber Signature Date

Delta Use Only

_____
Entered

_____
Operator #