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| **DENTAL ENROLLMENT FORM** | **Group # 07709**Delta Dental PPO plus Premier/Advantage Program |
| **Name of Employer****Summit Board of Education** | **Effective Date of Coverage** **7.1.17** |
| **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** |
|  **/ /**  | * **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:** |
| **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 #** |