|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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 #** | | |