RE: Dependent:

Please complete and return this form either by fax to (973) 285-4141 or by mail to:
The Customer Service Department Attention: Correspondence.

(I) MEMBER INFORMATION

Member Name: _____Date of Birth: _____ / _____ / _____

Member ID# (this could be Member Social Security Number):_____

Daytime Phone Number: (_____) _____ - _____ Employer Name_____

Delta Dental Assigned Group Number: _____ - _____ Cobra Plan: Yes or No (circle one)

(II) SECONDARY COVERAGE WITH DELTA DENTAL OF NEW JERSEY (if applicable)

Member Name: _____Date of Birth: _____ / _____ / _____

Member Social Security Number: _____ - _____ - _____

Daytime Phone Number: (_____) _____ - _____ Employer Name_____

Delta Dental Assigned Group Number: _____ - _____ Cobra Plan: Yes or No (circle one)

(III) DEPENDENT INFORMATION:

Dependent Name: _____Date of Birth: _____ / _____ / _____

Dependent's Social Security Number: _____ - _____ - _____

Student Identification Number (if SSN not used): _____

Name of College: _____College Phone Number: (_____) _____ - _____

Undergraduate or Graduate Student: (circle one) Number of Credits: _____

Semester: Fall or Spring (circle one) Year: 20__ __

(IV) SIGNATURES

By signing this form, I attest that all information is complete and accurate.
I authorize Delta Dental of New Jersey to contact the college for further verification if necessary.
If the above information should change, I will inform Delta Dental of New Jersey immediately.

Primary Member's Name (Print) _____

Primary Member's Signature: _____Date: _____ / _____ / _____

Secondary Member's Name (Print) _____

Secondary Member's Signature: _____Date: _____ / _____ / _____

Delta Dental of New Jersey, Inc.
Delta Dental Plaza
1639 Route 10
Parsippany, NJ 07054

Telephone: 973-285-4000
Claims Inquiries:800-452-9310
Fax:973-285-4140