



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: \_\_\_\_/\_\_\_\_/\_\_\_\_