DELTA DENTAL

ENROLLMENT FORM

SOCIAL SECURITY NUMBER

___-___-____

Delta Dental of Tennessee
240 Venture Circle
Nashville, TN 37228
Telephone 615-255-3175

GROUP NUMBER _____ SUB-GROUP NUMBER _____ GROUP NAME _____

FIRST NAME	M	LAST NAME

STREET ADDRESS

CITY	STATE	ZIP

BIRTH DATE		EFFECTIVE DATE		SEX	M	F
					☐	☐

If enrolling spouse and/or dependents, please list them below

FIRST NAME & M.I. (LAST NAME IF DIFFERENT)	SEX		BIRTH DATE
	M	F	
SPOUSE:			
CHILD:			
CHILD:			
CHILD:			
CHILD:			

I agree to make the required contribution. I certify that the information contained in this form is true and correct to the best of my ability.

Signature: _____ Date: _____

DECLINE COVERAGE

I have been given the opportunity to apply for group dental insurance coverage through my employer and choose at this time to not take coverage. I understand that by signing this area I am declining this coverage because:

☐ I have other dental coverage ☐ I do not want at this time ☐ Other: _____

Declination Signature: Date: