DENTAL ENROLLMENT FORM

Eight Digit Group Number

☐ Delta Dental PPO^{SM} plus Premier

#10413 - 00001

☐ Delta Dental PPO^{SM} plus Premier COBRA

#10413 - 00002

Name of Employer	Effective Date of Coverage
PINE BELT ENTERPRISES	

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 #