DENTAL ENROLLMENT FORM

Eight Digit Group Number

☐ Delta Dental Premier® 3581 - 0001

☐ Delta Dental PPO℠ 3581 - 6001

☐ DeltaCare® 3581 - 9001

Name of Employer	Effective Date of Coverage
PUBLIC EMPLOYEES SUPERVISOR'S UNION	

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:**

If choosing DeltaCare®, you must complete this section

	Choice of Dentist	Office Number	For Delta Dental Use Only
1			
2			
3			

Optional choices will be selected if a provider terminates his/her participation agreement with Flagship. I authorize the release to Flagship Dental Plans of all my treatment information as a DeltaCare® subscriber and the treatment information of my dependent(s). I understand that I may change my primary Plan Participating Dentist by calling or in writing provided that a request for such change is received by Flagship at least thirty (30) days prior to the new contract month. Request received by the tenth (10th) of the month will be effective the first (1st) of the following month.

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 #