DELTA DENTAL®

DENTAL ELECTION MUST BE RECEIVED BY FUND OFFFICE BY 3/21/23

DENTAL ENROLLMENT FORM

Monthly Premium Rates

Single - $49.00
Two Person - $93.00
Family - $120.00

GROUP NAME	EFFECTIVE DATE
NORTH ATLANTIC STATES CARPENTERS	**April 1, 2023**

LAST Name(subscriber)	FIRST NAME	
SOCIAL SECURITY (SSN)	DATE OF BIRTH	GENDER F / M

HOME ADDRESS	CITY	STATE	ZIP CODE

PLEASE LIST ALL ELIGIBLE DEPENDENT(S) COVERED UNDER YOUR POLICY

FIRST NAME	LAST NAME (IF DIFFERENT FROMSUBSCRIBER)	DATE OF BIRTH	M/F	CHECK IF DEPENDENT IS OVER 19 AND A FULL-TIME STUDENT
SPOUSE				
CHILD				
CHILD				
CHILD				

Completed by the fund office

Enroll member in dental subgroup number:

____ Hours Based Active 007550010

____ HRA Active 0075250011

____ HRA Retiree 0075250012

Print Name _____ Signature _____ Date _____