



ENROLLMENT FORM

Delta Dental of Tennessee
 240 Venture Circle
 Nashville, TN 37228-1699
 Telephone 615-255-3175

SOCIAL SECURITY NUMBER

| | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
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GROUP NUMBER 7551 SUBLOCATION NUMBER _____ GROUP NAME Hamblen County Board of Education

| | | |
|-----------------------|--------------------------|---------------------------------------------------------------------|
| FIRST NAME | M | LAST NAME |
| | <input type="checkbox"/> | |
| STREET ADDRESS | | |
| | | |
| CITY | STATE | ZIP |
| | | |
| BIRTH DATE | EFFECTIVE DATE | SEX |
| | | <input type="checkbox"/> M <input type="checkbox"/> 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: _____