DELTA DENTAL

Forwarding Service Requested

Remit Payment To:

Delta Dental
Post Office Box 999
Anywhere, USA 55555-0000

Email: eligibility@deltadentalxx.com

ELIGIBILITY WORKSHEET

Please attach a complete enrollment form for additions, date changes and coverage type changes.

Group Number				
Group Name			Date	
Completed By			Phone	

ACTION 1 = Addition 2 = Termination 3 = Date Change 4 = Coverage Type

Action Code	Employee Social Security #	Employee Last Name	Employee First Name	Effective Date of Action	Coverage Type