DELTA DENTAL
Delta Dental Plan of New Jersey

Deletion/Change/Transfer Transmittal Sheet

DELTA DENTAL USE ONLY
ENT______________
OPER______________

GROUP#____________-____________ GROUP NAME ____________________________________ DATE ____________________________

CONTACT NAME____ TELEPHONE NUMBER (________)_______-_________EXT________

(PLEASE PRINT CLEARLY USING CAPITAL LETTERS)

Name Last / First	Subscriber's Social Security	Elig Code*	Effective/Term. Date	Nature of Change**	Changed From	Date of Birth	Employee Number	Action Code***	Old Sub-Loc
☐ Address Change	Street:			Apt:	City:		State:		Zip:
☐ Address Change	Street:			Apt:	City:		State:		Zip:
☐ Address Change	Street:			Apt:	City:		State:		Zip:
☐ Address Change	Street:			Apt:	City:		State:		Zip:
☐ Address Change	Street:			Apt:	City:		State:		Zip:
☐ Address Change	Street:			Apt:	City:		State:		Zip:
☐ Address Change	Street:			Apt:	City:		State:		Zip:
☐ Address Change	Street:			Apt:	City:		State:		Zip:

<u>* Eligibility Code:</u>
1-employee
2-employee & spouse
3-full family coverage
4-super-composite
5-employee & child
6-employee & children

<u> Nature of Change:</u>**
N/C-name change
R/C-rate change
ED/C-effective date change
SS#/C-Social Security number change

<u>* Action Code:</u>**
Trn.-Transfer
Del.-Deletion
Chg.-Change

Prepared
____
Checked
____

Please submit this sheet to Delta Dental at the following address by the 10th of each month: P.O. Box 23700, Newark, NJ 07189-0001.

Instructions for completing this form. Delta Dental must receive this form by the **10th of each month** to be reflected on the following month's bill.

ADDITIONS: **Please have the employee complete and submit Delta Dental's Enrollment Form.**

DELETIONS:
a) Subscriber's full name.
b) Social Security number.
c) Eligibility code - check the most current monthly dues billing for "bill code".
d) Effective date of termination - indicate the date of termination of benefits.
e) Indicate “DEL.” in the Action Code column.

CHANGES:
a) Subscriber's correct or current full name.
b) Correct Social Security number.
c) If adding/deleting spouse/dependents, provide new eligibility code in eligibility code column.
d) Effective date of change.
e) Provide nature of change.
f) Provide data changed from in the Data Changed From column.
g) Date of birth.
h) Provide Action Code “CHG” in the Action Code column.

TRANSFERS:
a) Subscriber's full name.
b) Social Security number.
c) Indicate “TRN” in the Action Code column.
d) List the old sub-location number in the Old Sub-Loc. column.

PLEASE NOTE:

1) Separate sheets must be submitted for each sub-location or group number your contract accommodates. Please do not combine sub-location or group numbers on a single sheet.

2) The original forms should be remitted by the 10th of each month to be reflected on the following month's bill.

3) Before submitting forms to Delta Dental, please verify that these adjustments are not duplicates of previously submitted forms. If you're submitting a form to update information previously submitted incorrectly, please indicate that in writing on the new form.

4) If additional forms are needed, please use the enclosed reorder postcards. **PLEASE DO NOT PHOTOCOPY**. Delta Dental uses the color-coding for processing purposes.

5) Entries on these forms **MUST BE LEGIBLE** to ensure proper claims processing.

6) Any illegible or incomplete information will delay eligibility processing which could affect your monthly bill and accurate claims processing

7) This form plus the Delta Dental enrollment form are the only forms accepted by Delta Dental to enroll or change eligibility records. Alternate forms will be returned.

8) Delta Dental will accept eligibility updates by facsimile. Please fax all updates **with a cover sheet** indicating the phone number and name of contact to call if information is incomplete or illegible. Fax eligibility updates to the Delta Dental Premium Billing Department at (973) 285-4142.

9) Please complete the contact name and telephone number, so we can verify any questions that may arise.

If you have any questions regarding eligibility submission, please contact Delta Dental's Premium Billing Department at (973) 285-4144.