**Eligibility Letter**

**(TO BE SUBMITTED ON GROUP LETTERHEAD ONLY)**

Date

Delta Dental of New Jersey & Connecticut

Company Name

Company Street Address

Company City, State, Zip

ATTN: Alexis-Rose Millar Delta Dental NJ & CT

I, Company Contact Name , on behalf of Company Name , am confirming that we have a total of Insert Total # of Employees  employees. All our employees enrolling in the Delta Dental of NJ/CT Dental Plan should be effective on Select Effective Date here.

Listed below are all our current Employees indicating who is enrolling, waiving due to other coverage, refusal (not covered elsewhere), or are ineligible.

|  |  |  |  |
| --- | --- | --- | --- |
| Enrolling | Waiving (*Covered Elsewhere*) | Refusal (*Not Covered Elsewhere*) | Not  Eligible |
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|  |  |  |  |
| Total # | Total # | Total # | Total # |

1. Jane Doe
2. John Smith
3. Jess River
4. Joe Stone
5. Employee Name
6. Employee Name
7. Employee Name
8. Employee Name
9. Employee Name
10. Employee Name

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Company Officer Please print (Officer Name)

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Title of Company Officer