Enrollment/ Change Form

DELTA DENTAL®

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(717) 766-8500 (800) 932-0783
TTY/TDD (888) 373-3582
www.MidAtlanticDeltaDental.com

Please check the applicable box or boxes.

☐ **New enrollment** ☐ **Address change**
☐ **COBRA** ☐ **Change of dependents**
☐ **Coverage change** ☐ **Termination**
☐ **Name change** ☐ **Decline Coverage**

☐ **Delta Dental PPO Plus Premier**

Please check the Delta Dental plan that administers your dental benefits.

☐ Delta Dental of Pennsylvania
☐ Delta Dental of New York
☐ Delta Dental Insurance Company
☐ Delta Dental of Delaware
☐ Delta Dental of West Virginia

Primary Enrollee Social Security Number	Last Name	First Name	MI	Date of Birth	Gender ☐ Male ☐ Female

Alternate Identification Number *(if applicable)*

Address (Is this a change of address? ☐ Yes ☐ No) Street City State Zip Code

Group Number: 9475 **Sublocation**

Change of Coverage

New Coverage: Former Coverage:

Name Change

From: To:

Dependent Change

Please check one of the boxes: ☐ Add dependent(s) listed below ☐ Delete dependent(s) listed below

Do you or your dependents have other dental coverage?

☐ Yes ☐ No *If yes, please complete the following:*

Carrier Name and Address: _____

Group Number: _____

Last name (if different)	First Name	MI	Gender	Date of Birth	Social Security Number
Spouse / Domestic Partner			M F		
Children			M F		
			M F		
			M F		
			M F		
			M F		

Date of Hire:	Effective Date:	Primary Enrollee Signature

Any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. Enrollees whose company is headquartered in the state of New York and who commit a fraudulent insurance crime shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Submit