

Enrollment/ Change Form



Delta Dental of Pennsylvania

One Delta Drive
Mechanicsburg, PA 17055
(800) 932-0783
TTY/TDD (888) 373-3582
www.deltadentalins.com

Please check the applicable box or boxes.

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

Please check the applicable box.

- Delta Dental Premier®
- Delta Dental PPOSM
- Delta Dental PPO plus Premier

Primary Enrollee Social Security Number	Last Name	First Name	MI	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Alternate Identification Number <i>(if applicable)</i>	Address (Is this a change of address? <input type="checkbox"/> Yes <input type="checkbox"/> No)		Street	City	State Zip Code

Group Number 10841	Sublocation	Group Name Atlantic Industries
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Change of Coverage	Former Coverage:
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New Coverage:	Former Coverage:
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Name Change	From:	To:
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Dependent Change		
Please check one of the boxes: <input type="checkbox"/> Add dependent(s) listed below <input type="checkbox"/> Delete dependent(s) listed below		

Do you or your dependents have other dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please complete the following:</i>		Carrier Name and Address: _____
		Group Number: _____

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

Date of Hire:	Effective Date:	Primary Enrollee Signature
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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, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.