

Enrollment/ Change Form



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 or boxes.

- Delta Dental Premier®
- Delta Dental PPOSM
- Delta Dental PPO Plus Premier
- DeltaCare® USA

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 <input type="checkbox"/> Male <input type="checkbox"/> Female
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Alternate Identification Number (if applicable)	Address (Is this a change of address? <input type="checkbox"/> Yes <input type="checkbox"/> No)	Street	City	State	Zip Code
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Group Number	Sublocation	Group Name
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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: _____ **Name of Insurer**

Group Number: _____