

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.

- Buy-Up Option**
- Base Option**
- Delta Dental PPO Plus Premier**

Delta Dental of Pennsylvania

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 (if applicable)	Address (Is this a change of address? <input type="checkbox"/> Yes <input type="checkbox"/> No)		Street	City	State Zip Code

Group Number 06418	Sublocation	Group Name PHYSICIANS ENDOSCOPY
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Do you or your dependents have other dental coverage? Yes No *If yes, please complete the following:*

Add dependent(s) listed below
Carrier Name and Address: _____
Group Number: _____

Delete dependent(s) listed below

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 _____
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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. 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.