

Enrollment/ Change Form



One Delta Drive, Mechanicsburg, PA 17055
 (717) 766-8500 (800) 932-0783
 TTY/TDD (888) 373-3582
 www.MidAtlanticDeltaDental.com

<p>Please check the applicable box or boxes.</p> <p><input type="checkbox"/> New enrollment <input type="checkbox"/> Address change <input type="checkbox"/> COBRA <input type="checkbox"/> Change of dependents <input type="checkbox"/> Coverage change <input type="checkbox"/> Termination <input type="checkbox"/> Name change <input type="checkbox"/> Decline Coverage</p>	<p>Please check the applicable box or boxes.</p> <p><input type="checkbox"/> Delta Dental Premier <input type="checkbox"/> Delta Dental PPO <input type="checkbox"/> Delta Dental PPO with POS <input type="checkbox"/> DeltaCare USA</p>	<p>Please check the Delta Dental plan that administers your dental benefits.</p> <p><input type="checkbox"/> Delta Dental of Pennsylvania <input type="checkbox"/> Delta Dental of New York <input type="checkbox"/> Delta Dental Insurance Company <input type="checkbox"/> Delta Dental of Delaware <input type="checkbox"/> Delta Dental of West Virginia</p>
---	---	--

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

Group Number # 1197	Sublocation N/A	Group Name Loyalsock Township School District
-------------------------------	---------------------------	---

DeltaCare UA Primary Care Dentist (required for DeltaCare USA enrollees)	DeltaCare USA Primary Dental Office ID No. (required for DeltaCare USA enrollees)
--	---

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			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.