



ENROLLMENT/CHANGE FORM

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

Group Administrators: Please return the completed form (s) via email to: DDPErollment@deltadentalpa.org
 To ensure timely processing of enrollment, please include all *fields on the enrollment form

Please check the applicable box or boxes <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 Changes <input type="checkbox"/> Decline Coverage		Please check the applicable box or boxes <input type="checkbox"/> Delta Dental Premier® <input type="checkbox"/> Delta Dental PPO SM <input type="checkbox"/> Delta Dental PPO plus Premier <input type="checkbox"/> DeltaCare® USA		Please check the Delta Dental plan that administers your dental benefits. <input type="checkbox"/> Delta Dental of Delaware <input type="checkbox"/> Delta Dental of the District of Columbia <input type="checkbox"/> Delta Dental of New York <input type="checkbox"/> Delta Dental of Pennsylvania <input type="checkbox"/> Delta Dental of West Virginia	
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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 new address?)* <input type="checkbox"/> Yes <input type="checkbox"/> No		Street	City	State Zip

Group Name*	Group Number*	Sublocation or Division*
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DeltaCare USA Primary Care Dentist (required for DeltaCare USA enrollees)	DeltaCare USA Primary Office ID No. (required for DeltaCare USA enrollees)
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Change of Coverage 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	Carrier Name and Address
If yes, please provide the information in the boxes to the right.	
Group Number	

Last Name*	First Name*	MI	Gender*	Date of Birth*	Social Security Number
			<input type="checkbox"/> Male <input type="checkbox"/> Female		
			<input type="checkbox"/> Male <input type="checkbox"/> Female		
			<input type="checkbox"/> Male <input type="checkbox"/> Female		
			<input type="checkbox"/> Male <input type="checkbox"/> Female		
			<input type="checkbox"/> Male <input type="checkbox"/> Female		
			<input type="checkbox"/> Male <input type="checkbox"/> Female		

Date of Hire:	Effective Date:*	Primary Enrollee Signature:*
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