

Enrollment/ Change Form



Delta Dental of New York

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

Primary Enrollee Social Security Number

Last Name

First Name

Date of Birth

Gender
 Male
 Female

Alternate Identification Number (if applicable)

Address
(Is this a change of address?)
 Yes No

Street

City

State

Zip Code

Group Number

04474

Sublocation

Group Name

VOORHEESVILLE CENTRAL SCHOOL DISTRICT

Change of Coverage

New Coverage:

Name Change

From:

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:

Former Coverage:

To:

Last name (if different)

First Name

MI

Gender

Date of Birth

Social Security Number

Spouse

M F

M F

M F

M F

M F

M F

M F

Children

M F

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, 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.