

Enrollment/Change Form



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

State _____ (to
 be completed by Delta)

Please check the applicable box or boxes.

- New enrollment
 Coverage change
 Address change
 Termination
 DeltaCare (DHMO)
- COBRA
 Name change
 Change of dependents

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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Address (Is this a change of address? Yes No) Street City State Zip Code

Date of Hire	Group Number 2019	Sublocation	Group Name The New School
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DeltaCare Primary Care Dentist (required for DeltaCare enrollees)	DeltaCare Primary Dental Office ID No. (required for DeltaCare enrollees)
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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: _____
 Group Number: _____

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		

Effective Date: _____ Primary Enrollee Signature _____