

Enrollment/ Change Form



Delta Dental of New York

Please check the applicable box or boxes.

- New enrollment** **Address change**
 COBRA **Change of dependents**
 Coverage change **Termination**
 Name change **Decline Coverage**

Please check the applicable box or boxes.

- Delta Dental Premier®**
 Delta Dental PPOSM
 Delta Dental PPO Plus Premier

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 Mechanicsburg, PA 17055
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 TTY/TDD (888) 373-3582
 www.deltadentalins.com

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 2220	Sublocation	Group Name BETHLEHEM CENTRAL TEACHERS' ASSOCIATION
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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			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, 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.