

Enrollment/Change Form

State
(to be completed by Delta)



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

Please check the applicable box or boxes.

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

Delta Preferred Option with POS

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 2509	Sublocation	Group Name Utica College
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DeltaCare Primary Care Dentist (required for DeltaCare enrollees) _____
 DeltaCare Primary Dental Office ID No. (required for DeltaCare 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		

Effective Date: _____ Primary Enrollee Signature _____