

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
 DeltaPreferred Option with POS
 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 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)
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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		

Effective Date:	Primary Enrollee Signature
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