

Enrollment Change Form



Delta Dental of New York

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
- DeltaCare® USA

One Delta Drive
Mechanicsburg, PA 17055
(800) 932-0783
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	Sublocation	Group Name
DeltaCare USA Primary Care Dentist (required for DeltaCare USA enrollees)		DeltaCare USA Primary Dental Office ID No. (required for DeltaCare USA enrollees)

Change of Coverage	Former Coverage:
New 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.