

# 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  
 COBRA     
  Name change     
  Change of dependents

- DeltaPremier  
 DeltaPreferred Option (PPO)  
 DeltaPreferred Option with POS  
 DeltaCare (DHMO)

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	Sublocation	Group Name
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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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