DELTA DENTAL®

ENROLLMENT/CHANGE FORM

Delta Dental

☐ Core (Low Plan) ☐ Enhanced (High Plan)

Delta Dental
One Delta Drive
Mechanicsburg, PA 17055-6999
deltadentalins.com

VERY IMPORTANT — Please Print Legibly

FOR GROUP USE ONLY

Group No.	Division	State

Effective Date / /	Hire Date / /

Name of Employer

Location	Pay Code	Benefit Package

Enrollee/Change Information

☐ New Enrollment ☐ Marital Status Change ☐ Terminate Enrollee Coverage ☐ SSN/Enrollee ID Number Correction or previous ID under which benefits are received

☐ Add/Delete Dependent ☐ Address Change ☐ Other _____

Enrollee Classification

☐ Full-Time ☐ Hourly ☐ Certified

☐ Part-Time ☐ Salaried ☐ Classified

☐ Retired ☐ Member/Other _____

COBRA (if applicable)

☐ Termination

☐ Reduction in Hours

☐ Divorce/Legal Separation*

☐ Widowed/Surviving Dependent*

☐ Dependent Child No Longer Eligible*

Indicate qualifying date: ___/___/___

*If a dependent is enrolling under his/her social security number, the **SSN currently enrolled under must be provided**.

Primary Enrollee Information

Social Security Number	Enrollee ID Number (if applicable)	Date of Birth	Gender	Marital Status
		/ /	☐ Non-binary ☐ Male ☐ Female	☐ Single ☐ Married

First Name	Last Name	Middle Initial

Mailing Address (Street)	City	State	ZIP Code

Email Address (internal use only)	Phone Number ( ) -	Phone Type Cell ☐ Work ☐ Home ☐

Name of Other Dental Carrier	Policy Holder Name (first/last)	Date of Birth / /

Effective Date of Other Policy / /	Policy Holder Street Address	City	State	ZIP Code

Dependent Information

Relationship	Dependent First Name (Last only if different from enrollee)	Add / Term	Social Security Number	Date of Birth	Non binary/ Male / Female	Student / Disabled**	Name of School (overage student)**
Spouse		☐ ☐		/ /	☐ ☐ ☐	☐ ☐	
Dependent		☐ ☐		/ /	☐ ☐ ☐	☐ ☐	
Dependent		☐ ☐		/ /	☐ ☐ ☐	☐ ☐	
Dependent		☐ ☐		/ /	☐ ☐ ☐	☐ ☐	
Dependent		☐ ☐		/ /	☐ ☐ ☐	☐ ☐	

Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled. **Additional documentation will be required for disabled and student status.

☐ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made during the annual open enrollment period unless I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contract.

☐ I decline coverage at this time.

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature of Enrollee _____ Date ___/___/___