Enrollment/Change Form

State
(to be completed by Delta)

Gettysburg Health Administrators, Inc.
404 Baltimore Street, PO Box 1060
Gettysburg, PA 17325
(800) 497-4474

Please check the applicable box or boxes.

☐ **New enrollment** ☐ **Coverage change** ☐ **Address change** ☐ **Termination**

☐ **Decline Coverage** ☐ **Name change** ☐ **Change of dependents** ☐ **COBRA**

☐ **DeltaPremier**
☐ **DeltaPreferred Option (DPO)**
☐ **DeltaPreferred Option (Voluntary)**
☐ **DeltaCare (DHMO)**

Primary Enrollee Social Security Number	Last Name	First Name	MI	Date of Birth	Gender ☐ Male ☐ Female

Address (Is this a change of address? ☐ Yes ☐No) Street City State Zip Code

Marital Status ☐ Single ☐ Married	Date of Hire	Group Number	Sublocation	Group Name

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 No. ____________________

	Last name (if different)	First Name	MI	Student	Handicapped	Gender	Date of Birth	Social Security No.
Spouse						M F		
Children				Y N	Y N	M F		
				Y N	Y N	M F		
				Y N	Y N	M F		
				Y N	Y N	M F		
				Y N	Y N	M F		

Effective Date:

Primary Enrollee Signature ____________________

Send this form to Gettysburg Health Administrators, Inc.
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GHA 8/04