

Enrollment/ Change Form



Delta Dental of New York
 One Delta Drive
 Mechanicsburg, PA 17055
 (800) 932-0783

Please check the applicable box or boxes.

- | | |
|--|---|
| <input type="checkbox"/> New enrollment | <input type="checkbox"/> Address change |
| <input type="checkbox"/> COBRA | <input type="checkbox"/> Change of dependents |
| <input type="checkbox"/> Coverage change | <input type="checkbox"/> Termination |
| <input type="checkbox"/> Name change | <input type="checkbox"/> Decline coverage |

Please check the applicable box or boxes.

- Delta Dental PPOSM
- Delta Dental PPO plus Premier
- DeltaCare[®] USA

Send this form to:

Gettysburg Health Administrators,
 Inc.
 34 Locust Avenue, PO Box 1060
 Gettysburg, PA 17325
 (800) 497-4474

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
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DeltaCare USA Primary Care Dentist (required for DeltaCare USA enrollees)	DeltaCare USA Primary Dental Office ID No. (required for DeltaCare USA enrollees)
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Change of Coverage	Former Coverage:
New Coverage:	

Name Change	To:
From:	

Dependent Change	<input type="checkbox"/> Add dependent(s) listed below	<input type="checkbox"/> Delete dependent(s) listed below
Please check one of the boxes:		

Do you or your dependents have other dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please complete the following:</i>	Carrier Name and Address: _____
	Group Number: _____

Last name (if different)	First Name	MI	Gender	Date of Birth	Social Security Number
Spouse / Domestic Partner			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.