

Enrollment/ Change Form

One Delta Drive, Mechanicsburg, PA 17055
(800) 932-0783
TTY/TDD (888) 373-3582
www.deltadentalins.com



Please check the applicable box or boxes.

New enrollment Address change
 COBRA Change of dependents
 Coverage change Termination
 Name change Decline Coverage

Please check the Delta Dental plan that administers your dental benefits.

Delta Dental of Pennsylvania
 Delta Dental of New York
 Delta Dental Insurance Company
 Delta Dental of Delaware
 Delta Dental of West Virginia

Primary Enrollee Social Security Number _____

Last Name _____ First Name _____ MI _____ Date of Birth _____ Gender Male Female

Alternate Identification Number (if applicable) _____

Address (Is this a change of address?) Yes No

Street _____ City _____ State _____ Zip Code _____

Group Number 2291 **Sublocation** _____ **Group Name** BRYN MAWR COLLEGE

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:

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 _____

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. Enrollees whose company is headquartered in the state of New York and who commit a fraudulent insurance crime shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.