

# 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.

- |  |   |
|--|---|
| <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     |

Delta Dental PPO<sup>SM</sup>

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 <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

<b>Group Number:</b> 2291	<b>Sublocation</b>	<b>Group Name:</b> BRYN MAWR COLLEGE
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Change of Coverage

Former Coverage:

Name Change

New Coverage: \_\_\_\_\_ 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) Spouse / Domestic Partner	First Name	MI	Gender	Date of Birth	Social Security Number
			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. 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.