Enrollment/ Change Form

DELTA DENTAL®

Delta Dental of New York

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Mechanicsburg, PA 17055
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(800) 932-0783
TTY/TDD (888) 373-3582
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Please check the applicable box or boxes.

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

Please check the applicable box or boxes.

- ■ Delta Dental PPO Plus Premier

UNDERGRADUATE STUDENT ONLY COVERAGE

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	Sublocation	Group Name
00975	0002	RENSSELAER STUDENT DENTAL - UNDERGRAD STUDENT

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 Number: _____

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