ENROLLMENT/CHANGE FORM

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

Group Administrators: Please return the completed form (s) via email to: DDPEnrollment@deltadentalpa.org
*To ensure timely processing of enrollment, please include all * fields on the enrollment form*

Please check the applicable box or boxes	*Please check the applicable box or boxes*	*Please check the Delta Dental plan that administers your dental benefits.*
❑ New Enrollment ❑ Coverage change ❑ Address Change ❑ Termination ❑ COBRA ❑ Name Changes ❑ Change of dependents ❑ Decline Coverage	❑ Delta Dental Premier® ❑ Delta Dental PPO℠ ❑ Delta Dental PPO plus Premier ❑ DeltaCare® USA	❑ Delta Dental of Delaware ❑ Delta Dental of the District of Columbia ❑ Delta Dental of New York ❑ Delta Dental of Pennsylvania ❑ 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 new address?)* ❑ Yes ❑ No	Street		City	State Zip

Group Name*	**Group Number***	**Sublocation or Division***
Cornwall Central School District	10890	

DeltaCare USA Primary Care Dentist (*required for DeltaCare USA enrollees*)	DeltaCare USA Primary Office ID No. (*required for DeltaCare USA 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 provide the information in the boxes to the right.*	Carrier Name and Address Group Number

Last Name*	First Name*	MI	Gender*	Date of Birth*	Social Security Number
			❑ Male ❑ Female		
			❑ Male ❑ Female		
			❑ Male ❑ Female		
			❑ Male ❑ Female		
			❑ Male ❑ Female		
			❑ Male ❑ Female		

Date of Hire:	Effective Date:*	Primary Enrollee Signature:*