DELTA DENTAL®

ENROLLMENT/CHANGE FORM - PA

Delta Dental of Pennsylvania

Small Business Program

PPO Only

VERY IMPORTANT - Please Print Legibly

Enrollee/Change Information

- ❑ New Enrollment
- ❑ Marital Status Change
- ❑ Terminate Enrollee Coverage
- ❑ SSN/Enrollee ID Number Correction or previous ID under which benefits are received
- ❑ Add/Delete Dependent
- ❑ Address Change
- ❑ Other _____

Primary Enrollee Information

Social Security Number	Date of Birth	Gender ❑ Male ❑ Female ❑ Non-binary	Marital Status ❑ Single ❑ Married
First Name		Last Name	Middle
Mailing Address (Street)		City	State / Zip
E-mail Address (internal use only)		Phone Number	Phone Type ❑ Cell ❑ Work ❑ Home
Name of Other Dental Carrier		Policy Holder Name (first/last)	Date of Birth
Effective Date of Other Policy	Policy Holder Street Address	City	State / Zip

FOR GROUP USE ONLY

Group No.	Division	State
Effective Date	Hire Date	
Name of Employer		

- ❑ Add/Term/Change Due to Qualifying Event
- ❑ Open Enrollment

Enrollee Classification

- ❑ Full-Time ❑ Hourly ❑ Certified
- ❑ Retired ❑ Salaried ❑ Classified
- ❑ Other _____

COBRA (if applicable)

- ❑ Termination
- ❑ Reduction in Hours
- ❑ Divorce/Legal Separation*
- ❑ Widowed/Surviving Dependent*
- ❑ Dependent Child No Longer Eligible*

Indicate qualifying date: _____

*If a dependent is enrolling under their own social security number, the **SSN currently enrolled under must be provided**.

Dependent Information[1]

Relationship	Dependent First Name (Last only if different from enrollee)	Add/Term	Date of Birth	Male/Female/Non-Binary	Disabled[2]
Spouse/Partner		❑ ❑		❑ ❑ ❑	❑
Dependent		❑ ❑		❑ ❑ ❑	❑
Dependent		❑ ❑		❑ ❑ ❑	❑
Dependent		❑ ❑		❑ ❑ ❑	❑
Dependent		❑ ❑		❑ ❑ ❑	❑

[1] Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled.

[2] Additional documentation, in the form of a doctor's note, will be required for disabled status.

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❑ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made during the annual open enrollment period unless I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contract.

❑ I have been offered coverage by my employer, but at this time I wish to decline dental coverage for:

❑ Myself and my dependents ❑ Spouse/Partner ❑ Child(ren)

Reason

Required only if employee waiving coverage — not required if waiving coverage for dependents only

❑ Other Group Coverage Carrier Name _____ Group #_____
❑ Medicare/Medicaid provided dental coverage
❑ Individual Policy
❑ Other Reason _____ (explanation required)

Any person who knowingly and with intent to defraud any insurance company or 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 subjects such person to criminal and civil penalties.

Signature of Enrollee _____ Date _____