Enrollment/ Change Form

DELTA DENTAL

Delta Dental of New York

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

■ **New enrollment**

■ **Delta Dental PPO℠ plus Premier**

Primary Enrollee Social Security Number	Last Name	First Name	MI	Date of Birth	Gender ☐ Male ☐ Female

Address (Is this a change of address? ☐ Yes ☐ No) Street City State ZIP Code

Group Number	**Sublocation**	**Group Name**
04508	0001	Sheet Metal Workers Local 83

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		

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.