



ENROLLMENT/CHANGE FORM — NY

Delta Dental of New York

Delta Dental of New York
 One Delta Drive
 Mechanicsburg, PA 17055-6999
 deltadentalins.com

VERY IMPORTANT — Please Print Legibly

Enrollee/Change Information			
<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Marital Status Change	<input type="checkbox"/> Terminate Enrollee Coverage	<input type="checkbox"/> SSN/Enrollee ID Number Correction or previous ID under which benefits are received
<input type="checkbox"/> Add/Delete Dependent	<input type="checkbox"/> Address Change	<input type="checkbox"/> Other _____	

Primary Enrollee Information				
Social Security Number	Enrollee ID Number (if applicable)	Date of Birth	Gender	Marital Status
		/ /	<input type="checkbox"/> Non-binary <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married
First Name		Last Name		Middle Initial
Mailing Address (Street)		City	State	ZIP Code
Email Address (internal use only)		Phone Number () -	Phone Type Cell <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/>	
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 Code

FOR GROUP USE ONLY		
Group No.	Division	State
Effective Date / /	Hire Date / /	
Name of Employer		
Location	Pay Code	Benefit Package
Enrollee Classification		
<input type="checkbox"/> Full-Time	<input type="checkbox"/> Hourly	<input type="checkbox"/> Certified
<input type="checkbox"/> Part-Time	<input type="checkbox"/> Salaried	<input type="checkbox"/> Classified
<input type="checkbox"/> Retired	<input type="checkbox"/> Member/Other _____	
COBRA (if applicable)		
<input type="checkbox"/> Termination		
<input type="checkbox"/> Reduction in Hours		
<input type="checkbox"/> Divorce/Legal Separation*		
<input type="checkbox"/> Widowed/Surviving Dependent*		
<input type="checkbox"/> Dependent Child No Longer Eligible*		
Indicate qualifying date: / /		
*If a dependent is enrolling under his/her social security number, the SSN currently enrolled under must be provided.		

Dependent Information								
Relationship	Dependent First Name (Last only if different from enrollee)	Add / Term	Social Security Number	Date of Birth	Non binary/ Male / Female	Student / Disabled**	Name of School (coverage student)**	
Spouse		<input type="checkbox"/> <input type="checkbox"/>		/ /	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		
Dependent		<input type="checkbox"/> <input type="checkbox"/>		/ /	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		
Dependent		<input type="checkbox"/> <input type="checkbox"/>		/ /	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		
Dependent		<input type="checkbox"/> <input type="checkbox"/>		/ /	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		
Dependent		<input type="checkbox"/> <input type="checkbox"/>		/ /	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		

Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled. **Additional documentation will be required for disabled and student status.

<input type="checkbox"/>	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.
<input type="checkbox"/>	I decline coverage at this time.
<i>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.</i>	
Signature of Enrollee _____	Date _____ / _____ / _____