



ENROLLMENT/CHANGE FORM - PA

Delta Dental of Pennsylvania
Small Business Program
PPO Only

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 _____	<input type="checkbox"/>

Primary Enrollee Information

Social Security Number	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	
First Name	Last Name		Middle	
Mailing Address (Street)	City	State	Zip	
E-mail Address (internal use only)	Phone Number	Phone Type <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> 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

Dependent Information¹

Relationship	Dependent First Name (Last only if different from enrollee)	Add/Term <input type="checkbox"/> <input type="checkbox"/>	Date of Birth	Male/Female/Non-Binary <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Disabled ² <input type="checkbox"/>
Spouse/Partner		<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"/>
Dependent		<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"/>
Dependent		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>

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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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.

DENTAL

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 _____