



# ENROLLMENT/CHANGE FORM - PA

Delta Dental of Pennsylvania  
Small Business Program

VERY IMPORTANT - Please Print Legibly

## FOR GROUP USE ONLY

Group No.	Division	State
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Effective Date	Hire Date
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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 his/her social security number, the SSN currently enrolled under must be provided.

## 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	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 Information

Relationship	Dependent First Name (Last only if different from enrollee)	Add/Term	Date of Birth	Male/Female	Disabled**
Spouse/Partner		<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"/>
Dependent		<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"/>
Dependent		<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 status.

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 decline coverage at this time.

*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 \_\_\_\_\_