DELTA DENTAL®

ENROLLMENT/CHANGE FORM — NY

Delta Dental of New York

Delta Dental of New York
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VERY IMPORTANT — Please Print Legibly

FOR GROUP USE ONLY

Group No.	Division	State
Effective Date / /	Hire Date / /	
Name of Employer		
Location	Pay Code	Benefit Package

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 _____

Enrollee Classification

❑ Full-Time ❑ Hourly ❑ Certified
❑ Part-Time ❑ Salaried ❑ Classified
❑ Retired ❑ Member/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**.

Primary Enrollee Information

Social Security Number	Enrollee ID Number (if applicable)	Date of Birth	Gender	Marital Status
		/ /	❑ Non-binary ❑ Male ❑ Female	❑ Single ❑ Married

First Name	Last Name	Middle Initial

Mailing Address (Street)	City	State	ZIP Code

Email 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 Code
/ /				

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 (overage student)**
Spouse		❑ ❑		/ /	❑ ❑ ❑	❑ ❑	
Dependent		❑ ❑		/ /	❑ ❑ ❑	❑ ❑	
Dependent		❑ ❑		/ /	❑ ❑ ❑	❑ ❑	
Dependent		❑ ❑		/ /	❑ ❑ ❑	❑ ❑	
Dependent		❑ ❑		/ /	❑ ❑ ❑	❑ ❑	

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.

❑ 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 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.

Signature of Enrollee _____ Date _____/_____/_____