

## **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** 

☐ New Enrollment		☐ Marital Status Change	☐ Terminate Enrollee Coverage		SSN/Enrollee ID Number Correction or previous ID under which benefits are received	its are received	☐ Full-Time
☐ Add/Delete Dependent	1	☐ Address Change	Other				
	1000	P	Primary Enrollee I	Enrollee Information			
Social Security Number	-	Enrollee ID Number (if applicable)		Date of Birth	Gender	Marital Status	- 1
First Name	-	Last Name	me			-	-
Mailing Address (Street)	et)				Crava	710	1
Common Co	1 200			City	State	ZIP Code	
Email Address (internal use only)	nai use only)	:	Phone	Phone Number	Phone Type	Phone Type	
Name of Other Dental Carrier	d Carrier		Policy Holder Name (first/last)	irst/last)	4	Date of Birth	
Effective Date of Other Policy	/ /	Policy Holder Street Address		City	State	ZIP Code	
				Dependent	Dependent Information		
Relationship	Dependent First Name (Last only if different fr	Dependent First Name (Last only if different from enrollee)	Add / Term	Social Security Number	Date of Birth	Non binary/ Male / Female	Student / Disabled**
Spouse			0 0		/ /	0	
Dependent			0 0	_	_ / /	000	
Dependent			0		/ /	0 0	
Dependent			0		/ /	000	0
Dependent					/ /	0 0	
lease attach a separa	e sheet for add	itional dependent information. A	l dependents listed will be c	considered enrolled. "Add	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	uired for disabled and sl	udent
l authoriz I understa consisten	e any payro and that cha t with that e	l authorize any payroll deduction that may be required towards the cost of this conderstand that changes can only be made during the annual open enrollment performs that event, or as may otherwise be provided by the group contract.	e required towards to during the annual op se be provided by the	he cost of this cove ben enrollment peri e group contract.	l 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 knowle 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 musconsistent with that event, or as may otherwise be provided by the group contract.	oove information i	s true
l decline	I decline coverage at this time	this time.					
Any person v	vho knowii iy materiai	ngly and with intent to lly false information o	defraud any insur	ance company or urpose of mislead	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	an application f erning any fact m	or in
	t which in	a crime and shall he		1114. 24444 1764	insurance act which is a crime and shall be subject to a still non-its and to exceed the thousand deli-		

FOR GROUP USE ONLY

	I CIN CIN	COL COL CUIL
Gro	Group No.	Division
Effec Date	Effective /	/ Hire / /
Nam	Name of Employer	
Loca	Location	Pay Code Benefit Package
	Enrollee	e Classification
	Full-Time	Hourly Certified
0	Part-Time	Salaried Classified
0	Retired 🔲	Member/Other
	COBRA (if	(if applicable)
	Termination	
	Reduction in Hours	ours
	Divorce/Legal Separation*	Separation*
	Widowed/Surviving	rving Dependent*
	Dependent Chi	Dependent Child No Longer Eligible*
Indicate	ate qualifying date	te//
num prov	"If a dependent is enro number, the SSN curro provided.	"If a dependent is enrolling under his/her social security number, the SSN currently enrolled under must be provided.

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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	containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent	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	i decline coverage at this time.	consistent with that event, or as may otherwise be provided by the group contract.	I understand that changes can only he made during the applied open envolved lighter I experience a modificient facility that the above information is true and correct to the best of my knowledge.	The state of the s

Signature of Enrollee

Date