Enrollment/ Change Form

DELTA DENTAL

Send this form to:
Allied Administrators
PO Box 26908
San Francisco, CA 94126
phone: (877) 472-2669 fax: (415) 874-3960

Please check the applicable box or boxes.

- ☐ **New enrollment**
- ☐ **COBRA**
- ☐ **Coverage change**
- ☐ **Name change**
- ☐ **Address change**
- ☐ **Change of dependents**
- ☐ **Termination**
- ☐ **Decline coverage**

Please check the applicable box or boxes.

- ☐ **Delta Dental PPO℠**
- ☐ **Delta Dental PPO plus Premier**
- ☐ **DeltaCare® USA**

Please check the Delta Dental plan that administers your dental benefits.

- ☐ Delta Dental of Pennsylvania
- ☐ Delta Dental Insurance Company
- ☐ Delta Dental of Delaware
- ☐ Delta Dental of West Virginia

Primary Enrollee Social Security Number	Last Name	First Name	MI	Date of Birth	Gender
					☐ Male ☐ Female

Alternate Identification Number *(if applicable)*

Address
(Is this a change of address?
☐ Yes ☐ No)
Street City State Zip Code

Group Number	**Sublocation**	**Group Name**

DeltaCare USA Primary Care Dentist *(required for DeltaCare USA enrollees)*

DeltaCare USA Primary Dental Office ID No. *(required for DeltaCare USA enrollees)*

Change of Coverage

New Coverage: Former Coverage:

Name Change

From: To:

Dependent Change

Please check one of the boxes: ☐ Add dependent(s) listed below ☐ Delete dependent(s) listed below

Do you or your dependents have other dental coverage?

☐ Yes ☐ No *If yes, please complete the following:*

Carrier Name and Address: _____

Group Number: _____

Last name (if different)	First Name	MI	Gender	Date of Birth	Social Security Number
Spouse / Domestic Partner			M F		
Children			M F		
			M F		
			M F		
			M F		
			M F		

Date of Hire:	Effective Date:	Primary Enrollee Signature

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. Enrollees whose company is headquartered in the state of New York and who commit a fraudulent insurance crime shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.