

# Enrollment/ Change Form



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

**Please check the applicable box or boxes.**

- |   |  |
|---|--|
| <input type="checkbox"/> <b>New enrollment</b>  | <input type="checkbox"/> <b>Address change</b>       |
| <input type="checkbox"/> <b>COBRA</b>           | <input type="checkbox"/> <b>Change of dependents</b> |
| <input type="checkbox"/> <b>Coverage change</b> | <input type="checkbox"/> <b>Termination</b>          |
| <input type="checkbox"/> <b>Name change</b>     | <input type="checkbox"/> <b>Decline Coverage</b>     |

**Please check the applicable box or boxes.**

- ☐ **Delta Dental PPO<sup>SM</sup>**  
☐ **Delta Dental PPO Plus Premier**  
☐ **DeltaCare<sup>®</sup> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female
Alternate Identification Number (if applicable)	Address (Is this a change of address? <input type="checkbox"/> Yes <input type="checkbox"/> No)				
	Street	City	State	Zip Code	

<b>Group Number</b>	<b>Sublocation</b>	<b>Group Name</b>
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DeltaCare USA Primary Care Dentist (required for DeltaCare USA enrollees)	DeltaCare USA Primary Dental Office ID No. (required for DeltaCare USA enrollees)
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Change of Coverage
New Coverage: _____ Former Coverage: _____

Name Change
From: _____ To: _____

Dependent Change
Please check one of the boxes: <input type="checkbox"/> Add dependent(s) listed below <input type="checkbox"/> Delete dependent(s) listed below

Do you or your dependents have other dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete the following:	Carrier Name and Address: _____ Group Number: _____
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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 _____
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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.