

# Enrollment/Change Form

## Open Enrollment

### Delta Dental of New York

(717) 766-8500

(800) 932-0783

TTY/TDD (888) 373-3582

[www.MidAtlanticDeltaDental.com](http://www.MidAtlanticDeltaDental.com)

Please check the applicable box or boxes:

<input type="checkbox"/> New enrollment	<input type="checkbox"/> Address Change
<input type="checkbox"/> COBRA	<input type="checkbox"/> Change of Dependents
<input type="checkbox"/> Coverage Change	<input type="checkbox"/> Termination
<input type="checkbox"/> Name Change	<input type="checkbox"/> Decline Coverage

### Delta Dental PPO

Primary Enrollee Social Security Number

Last Name

First Name

MI

Date of Birth

Gender

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

Alternate ID Number (if applicable)

Address: Street

City

State

Zip Code

Group Number

**09670 0002**

Group Name

**ONONDAGA-CORTLAND-MADISON BOCES**

Check One:  Single Coverage  Family Coverage

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 the dependent(s) listed below

Do you or your dependents have other dental coverage:

Carrier Name and Address:

Yes  No

If yes, please complete the following:

Group Number:

#### Family Member Information:

Last Name

First Name

MI

Gender

Date of Birth

Social Security Number

Spouse

M

F

Children

M

F

Date of Hire:

Effective Date:

**01/01/26**

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, 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.