Enrollment/Change Form

Open Enrollment

Delta Dental of New York

(717) 766-8500
(800) 932-0783
TTY/TDD (888) 373-3582
www MidAtlanticDeltaDental.com

Please check the applicable box or boxes:

- ☐ New enrollment
- ☐ Address Change
- ☐ COBRA
- ☐ Change of Dependents
- ☐ Coverage Change
- ☐ Termination
- ☐ Name Change
- ☐ Decline Coverage

Delta Dental PPO

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

Alternate ID Number *(if applicable)*	Address: Street	City	State	Zip Code

Group Number	Sublocation	Group Name
09670	**0003**	**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 ☐		
	M ☐ F ☐		
	M ☐ F ☐		
	M ☐ F ☐		
	M ☐ F ☐		

Date of Hire:	Effective Date:	Primary Enrollee Signature
	01/01/26	

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.