

Enrollment/Change Form



One Delta Drive, Mechanicsburg, PA 17055
 (717) 766-8500 (800) 932-0783
 TTY/TDD (888) 373-3582
 www.MidAtlanticDeltaDental.com

State
 (to be completed by Delta)

New enrollment

Delta Care USA

Member Social Security Number	Last Name	First Name	MI	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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Address (Is this a change of address? Yes No) Street City State Zip Code

Group Number 2502	Group Name PSC - CUNY Welfare Fund
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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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Do you or your dependents have other dental coverage?
 Yes No *If yes, please complete the following:*

Member Signature _____	Carrier Name and Address: _____
	Group Number: _____

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

Effective Date::	Sublocation::
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