Enrollment/Change Form

State
(to be completed by Delta)

DELTA DENTAL®

Please return to :
PSC CUNY WELFARE FUND
61 Broadway,NY,NY 10006 15TH FL

Please check the applicable box or boxes.

☐ **New enrollment** ☐ **Coverage change** ☐ **Address change** ☐ **Termination**

☐ **COBRA** ☐ **Name change** ☐ **Change of dependents**

■ **Delta Care USA**

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

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

Date of Hire	Group Number	Sublocation	Group Name
	2502		PSC - CUNY Welfare Fund

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			M F		
Children			M F		
			M F		
			M F		
			M F		
			M F		

Effective Date:

Primary Enrollee Signature _____