Enrollment/ Change Form

DELTA DENTAL

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

Please check the applicable box or boxes.

- ☐ **New enrollment**
- ☐ **Change of dependents**
- ☐ **Termination**
- ☐ **Decline Coverage**
- ☐ **Address change**
- ☐ **Coverage change**
- ☐ **Name change**

Please check the applicable box or boxes.

- ☐ **Delta Dental PPO℠**
- ☐ **Delta Dental PPO℠ plus Premier**

Delta Dental of New Jersey, Inc.

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

Alternate Identification Number *(if applicable)*	Address (Is this a change of address? ☐ Yes ☐ No)	Street	City	State	Zip Code

Group Number	**Sublocation**	**Group Name**

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 / Domestic Partner (if coverage applies)			M F		
Children			M F		
			M F		
			M F		
			M F		
			M F		

Date of Hire:	Effective Date:	Primary Enrollee Signature

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

This contract does not include coverage of pediatric dental services that meet requirements of the federal Patient Protection and Affordable Care Act.

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