Enrollment/Change Form

State
(to be completed by Delta Dental)

DELTA DENTAL®

Allied Administrators
PO Box 26908
San Francisco, CA 94126
(877) SBA NOW or (877) 472-2669

Please check the applicable box or boxes.

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

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

☐ **Delta Dental Premier**
☐ **Delta Dental PPO**
☐ **Delta Dental PPO (Voluntary)**
☐ **DeltaCare 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

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 No.

Last name (if different)	First Name	MI	Student	Handicapped	Gender	Date of Birth	Social Security No.
Spouse					M F		
Children			Y N	Y N	M F		
			Y N	Y N	M F		
			Y N	Y N	M F		
			Y N	Y N	M F		
			Y N	Y N	M F		

Effective Date:

Primary Enrollee Signature _____

Send this form to Allied Administrators, Inc.
PO Box 26908, San Francisco, CA 94216

Or fax to : (415) 874-3960