

**DeltaCare<sup>®</sup> USA  
(DHMO program)**

*DHMO Plan Offers.....*

**Access only to Maryland, Pennsylvania, Florida, Georgia, Texas and Washington D.C.**

**DeltaCare USA Participating Dentists**

**For Enrollees of Government Employees' Benefit Association: (GEBA)**

**To locate a Maryland,  
Pennsylvania, Florida, Georgia,  
Texas or Washington D.C.  
DeltaCare USA dentist near you?**

**Please refer to the attached Dentist  
directory during open enrollment**

**OR**

**Contact Delta Dental's Customer  
Service department at:**

**(800) 932-0783**

**Please note when completing our  
enrollment form, you must complete the  
facility ID section. If this section is not  
completed, a dentist will be**

Enrollment/ Change Form		DELTA DENTAL		One Delta Drive, Mechanicsburg, PA 17055 (800) 932-0783 TTY/DD (888) 373-3582 www.deltadental.com	
<b>Please check the applicable box or boxes.</b> <input type="checkbox"/> New enrollment <input type="checkbox"/> Address change <input type="checkbox"/> COBRA <input type="checkbox"/> Change of dependents <input type="checkbox"/> Coverage change <input type="checkbox"/> Termination <input type="checkbox"/> Name change <input type="checkbox"/> Decline Coverage		<b>Please check the applicable box or boxes.</b> <input type="checkbox"/> Delta Dental Premier <sup>®</sup> <input type="checkbox"/> Delta Dental PPO <input type="checkbox"/> Delta Dental PPO Plus Premier <input type="checkbox"/> DeltaCare <sup>®</sup> USA		<b>Please check the Delta Dental plan that administers your dental benefits.</b> <input type="checkbox"/> Delta Dental of Pennsylvania <input type="checkbox"/> Delta Dental of New York <input type="checkbox"/> Delta Dental Insurance Company <input type="checkbox"/> Delta Dental of Delaware <input type="checkbox"/> Delta Dental of West Virginia	
Primary Enrollee Social Security Number	Last Name	First Name	MI	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Alternate Identification Number (if applicable)	Address (Is this a change of address?) <input type="checkbox"/> Yes <input type="checkbox"/> No		Street	City	State    Zip Code
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: <input type="checkbox"/> Add dependent(s) listed below <input type="checkbox"/> Delete dependent(s) listed below					
Do you or your dependents have other dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, please complete the following:					
Center Name and Address: _____					
Group Number: _____					
Last name (if different)		First Name	MI	Gender	Date of Birth
Spouse				M F	
Children				M F	
				M F	
				M F	
				M F	
				M F	
Date of Hire:		Effective Date:		Primary Enrollee Signature	
<small>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. Enrollees whose company is headquartered in the state of New York and who commit a fraudulent insurance crime shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.</small>					



*We keep you smiling<sup>®</sup>*