

# Enrollment/Change Form



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

State  
 (to be completed by Delta Dental)

**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 <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

Date of Hire	Group Number	Sublocation	Group Name
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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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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 \_\_\_\_\_