Enrollment/ Change Form

DELTA DENTAL

UUP Benefit Trust Fund

P.O. Box 15143
Albany, NY 12212-5143
800-887-3863
www.uupinfo.org

Please check the applicable box or boxes.

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

Please check

- ☐ **DeltaCare® USA**

NY State Employee ID	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**

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
Spouse / Domestic Partner			M F	
Children			M F	
			M F	
			M F	
			M F	
			M F	

Primary Enrollee Signature

_____

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, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.