



**MANUFACTURER'S ASSOCIATION**  
of Northwest Pennsylvania

*A Professional Employer Resource*



One Delta Drive, Mechanicsburg, PA 17055  
(717) 766-8500 (800) 932-0783  
TTY/TDD (888) 373-3582  
www.MidAtlanticDeltaDental.com

*Please check the applicable box or boxes.*

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

**Enrollment/Change Form**

Dental Plan Option \_\_\_\_\_

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	Street	City	State	Zip Code
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Date of Hire	Group Number	Sublocation (if known)	Company Name
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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 Number: \_\_\_\_\_

Last name (if different)	First Name	MI	Gender	Date of Birth	Social Security Number
Spouse			M F		
Children			M F		
			M F		
			M F		
			M F		
			M F		

Effective Date:	Primary Enrollee Signature
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