State
(To be completed by Allied)

Enrollment/Change Form

Gettysburg Health Administrators, Inc.
404 Baltimore Street, PO Box 1060
Gettsburg, PA 17325
(800) 497-4474

Please check the applicable box or boxes.

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

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

☐ **DeltaPremier**
☐ **DeltaPreferred Option (PPO)**
☐ **DeltaCare (DHMO)**

Primary Enrollee Social Security Number	Last Name	First Name	MI	Date of Birth	Sex ☐ 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 Primary Care Dentist (if applicable)	DeltaCare Dental Office ID No.

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 family members 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	Sex	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 of above changes:	Reason for above changes:	Subscriber Signature:

Send this form to Gettysburg Health Administrators, Inc.
404 Baltimiore St, PO Box 1060, Gettysburg, PA 17325