mda insurance
MDAPROGRAMS.COM

For Customer Service or Billing Questions
800-655-8838

For Enrollment
877-906-9924

Delta Dental Plan Enrollment or Change Form

Please type or print all information. Form must be signed by an MDA member dentist. Please fold and tape closed before mailing.

BILLING ADDRESS FOR P.C. OR PARTNERSHIP

PLEASE CHECK ONE:

☐ New Group Enrollment
☐ Addition: New Employee
Addition: ☐ Spouse
☐ Child
☐ Total Group Cancel
☐ Cancel Coverage: Subscriber & Dependent
Deletion: ☐ Spouse
☐ Child

(Please Print)
Change Name to: ______
Reason for Change (i.e., birth, marriage, divorce, etc.) ______
REQUESTED EFFECTIVE DATE ______
(Please refer to brochure for schedule)

Practice Name ______
Address ______
City ______ State ______ Zip ______
Business Phone ( ) ______ Business Fax ( ) ______ Email ______
MDA Member Name ______ Contact Person ______

Name ______ SS# ______ Birth Date ______ Sex ______
Address ______ City ______ State ______ ZIP ______
Plan Selection: ☐ **Premier 1** ☐ **Premier 2** Please check: ☐ Dentist ☐ Employee

List Dependents

Name	Sex	Birth Date	Name	Sex	Birth Date
Spouse			Child		
Child			Child		
Child			Child		

Name ______ SS# ______ Birth Date ______ Sex ______
Address ______ City ______ State ______ ZIP ______
Plan Selection: ☐ **Premier 1** ☐ **Premier 2** Please check: ☐ Dentist ☐ Employee

List Dependents

Name	Sex	Birth Date	Name	Sex	Birth Date
Spouse			Child		
Child			Child		
Child			Child		

Name ______ SS# ______ Birth Date ______ Sex ______
Address ______ City ______ State ______ ZIP ______
Plan Selection: ☐ **Premier 1** ☐ **Premier 2** Please check: ☐ Dentist ☐ Employee

List Dependents

Name	Sex	Birth Date	Name	Sex	Birth Date
Spouse			Child		
Child			Child		
Child			Child		

SURVIVING SPOUSE ONLY

Name of DECEASED ______
Social Security Number ______ Date of Death ___/___/___
Name of SURVIVING SPOUSE ______
Billing Address ______
Social Security Number ______ Date of Birth ___/___/___
Signature ______

– IMPORTANT INFORMATION –

- Subscribers are required to remain enrolled for a minimum of 24 consecutive months or unless terminated by employer.
- Applicants are free to choose either plan.

MDA Member Signature ______ **Date** ______

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