

# Annual Enrollment Form



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

Please check the applicable box or boxes.

- New enrollment
- Change of Address

Your dental plan is:  
**Delta Dental PPO<sup>SM</sup> plus Premier**

Group Name  
**Thomas Jefferson University - Student Plan**

Your dental plan administered by:

Delta Dental of Pennsylvania

Primary Enrollee Social Security Number	Campus Key	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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Group Number  <b>05097</b>	Base Plan <i>(Please check the applicable plan option and college below)</i>	Enhanced Plan <i>(Please check the applicable plan option and college below)</i>
	<input type="checkbox"/> Single (Annual Cost: \$133.00) <input type="checkbox"/> Family (Annual Cost: \$460.00) <input type="checkbox"/> Jefferson Medical College (Subloc. No. 0001) effective Aug. 1, 2010 through July 31, 2011 <i>Effective dates of coverage for following colleges are Sept. 1, 2010 through Aug.31, 2011</i> <input type="checkbox"/> Jefferson - Schools of Health Professions, Nursing, Pharmacy and Population Health (Sublocation No. 0002) <input type="checkbox"/> Jefferson College of Graduate Studies (Sublocation No. 0003)	<input type="checkbox"/> Single (Annual Cost: \$273.00) <input type="checkbox"/> Family (Annual Cost: \$947.00) <input type="checkbox"/> Jefferson Medical College (Subloc. No. 1001) effective Aug. 1, 2010 through July 31, 2011 <i>Effective dates of coverage for following colleges are Sept. 1, 2010 through Aug.31, 2011</i> <input type="checkbox"/> Jefferson - Schools of Health Professions, Nursing, Pharmacy and Population Health (Sublocation No. 1002) <input type="checkbox"/> Jefferson College of Graduate Studies (Sublocation No. 1003)

Do you or your dependents have other dental coverage?     Yes     No    *If yes, please complete the following:*

Add dependent(s) listed below                      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	

Primary Enrollee Signature \_\_\_\_\_ Date \_\_\_\_\_

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. Enrollees whose company is headquartered in the state of New York and who commit a fraudulent insurance crime shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.