Enrollment Form

State
(to be completed by Delta)

DELTA DENTAL®

☑ **New enrollment**

Please return to:
PSC-CUNY Welfare Fund
61 Broadway - 15th Floor
New York, NY 10036
Tel: (212) 354-5230 Fax: (212) 354-5363

☑ **Delta Care USA**

Member Social Security Number	Last Name	First Name	MI	Date of Birth	Gender
					☐ Male ☐ Female

Address *(Is this a change of address?* ☐ *Yes* ☐*No)* Street City State Zip Code

Group Number
2502

Group Name
PSC - CUNY Welfare Fund

DeltaCare USA Primary Care Dentist *(required for DeltaCare USA enrollees)*

DeltaCare USA Primary Dental Office ID No. *(required for DeltaCare USA enrollees)*

Do you or your dependents have other dental coverage?
☐ Yes ☐ No *If yes, please complete the following:*
Carrier Name and Address: _____

Member Signature _____

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::

Sublocation::

E/C-S0804