DELTA DENTAL

www.deltadentalpr.com

DELTA DENTAL ENROLLMENT / CHANGE FORM
(Formulario de Inscripción / Cambio)
Delta Dental of Puerto Rico, Inc.

☐ NEW GROUP / Grupo Nuevo ☐ MEMBER OR ASSOCIATE / Miembro o socio ☐ CHANGE / Cambio

GROUP NUMBER Número de Grupo:		**ENROLLMENT DATE** Fecha de Efectividad:		
**** SOC. SEC. /** Seg. Soc.	**LAST NAME** / Apellido	**FIRST NAME** / Nombre	**BIRTH DATE** / Fecha Nac. MM/DD/YY	**GENDER** / (Género) ☐ M ☐ F
POSTAL ADDRESS / Dirección Postal		**CITY** / Pueblo	State **PR**	**ZIP CODE**
Email / *Correo Electrónico*		**Phone /** *Teléfono*		
GROUP NAME / Nombre del Grupo		PLEASE INDICATE IF YOU OR ANY OF YOUR DEPENDENTS ARE COVERED BY ANOTHER DENTAL PLAN / Favor de indicar si usted o alguno de sus dependientes está cubierto por otro Plan Dental. ☐ **YES** / Sí ☐ **NO** / No		
**** ENROLLMENT DATE** / Fecha de inscripción		_____ NAME OF THE MAIN INSURED UNDER OTHER DENTAL PLAN NOMBRE DEL ASEGURADO PRINCIPAL BAJO OTRO PLAN DENTAL		
STATUS / Estatus ☐ SINGLE / Soltero ☐ MARRIED/ Casado ☐ DIVORCED/ Divorciado		_____ **** SOCIAL SECURITY / SEGURO SOCIAL**		
COVERAGE TYPE / Tipo de Cubierta ☐ INDIVIDUAL/individual ☐ PAREJA /Couple ☐ FAMILIA/Family				

LEGAL SPOUSE / Cónyuge Legal **OR**/ó **COHABITANT** / Cohabitante (if applicable / si aplica)

LAST NAME (IF DIFFERENT) Apellido (Si es diferente) **2.**	**FIRST NAME** & INITIAL Nombre e inicial	**SOCIAL SECURITY** Seguro Social	**GENDER** Género ☐ M ☐ F	**BIRTH DATE** Fecha de Nacimiento MM/DD/YY
***** ELIGIBLE DEPENDENTS** / Dependientes Elegibles				
3.			☐ M ☐ F	
4.			☐ M ☐ F	
5.			☐ M ☐ F	
6.			☐ M ☐ F	

REASON FOR CHANGE / Razón para cambio:

NOTE: PLEASE INDICATE TYPE OF CHANGE
Nota: Favor indicar tipo de cambio

☐ **ADDRESS CHANGE** Cambio de Dirección

☐ ***BIRTH / ADOPTION (DATE)** _____ Nacimiento / Adopción

☐ ***DEATH (DATE)** _____ Muerte

☐ ***ELIMINATE DEPENDENTS (Effective Date)** _____ Eliminar Dependientes

☐ ***ADD DEPENDENTS (Effective Date)** _____ Añadir Dependientes

☐ **OTHER (Explain) / Otros (Explicar)** _____

* SUPPORTING DOCUMENTS MUST BE SUBMITTED / Incluir evidencia correspondiente
** REQUIRED: INTERNAL USE ONLY / Requerido para uso interno solamente.
*** ELIGIBLE DEPENDENTS ARE COVERED UNTIL THEY REACH 26 YEARS OF AGE. / Los dependientes elegibles están cubiertos hasta que alcancen los 26 años de edad.

Cualquier persona que a sabiendas y que con la intención de defraudar presente información falsa en una solicitud de seguro o, que presentare, ayudare o hiciere presentar una reclamación fraudulenta para el pago de una pérdida u otro beneficio, o presentare más de una reclamación por un mismo daño o pérdida, incurrirá en delito grave y convicto que fuere, será sancionado, por cada violación con pena de multa no menor de cinco mil ($5,000) dólares, ni mayor de diez mil ($10,000) dólares o pena de reclusión por un término fijo de tres (3) años, o ambas penas. De mediar circunstancias agravantes, la pena fija establecida podrá ser aumentada hasta un máximo de cinco (5) años; de mediar circunstancias atenuantes, podrá ser reducida hasta un máximo de dos (2) años.

Any person who knowingly and with the intention to defraud presents false information in an insurance application or, who presents helps or has a fraudulent claim presented for the payment of a loss or other benefit, or presents more than one claim for the same loss or damage, will incur in a felony and if convicted, will be sanctioned for each violation with a fine of no less than five thousand ($5,000) dollars or no more than ten thousand ($10,000) dollars or imprisonment by the fixed term of three years, or both punishments. With aggravating circumstances, the fixed term of the punishment could go up to five (5) years; with mitigating circumstances the punishment could be reduced to a minimum of two (2) years.

I CERTIFY THAT THE INFORMATION CONTAINED IN THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY ABILITY.
Certifico por la presente que la información suministrada es correcta a mi mejor entender.

☐ **I WOULD LIKE TO RECEIVE ALL DOCUMENTS VIA EMAIL** Deseo recibir mis documentos por correo electrónico (email)

☐ **REGULAR MAIL (US MAIL)** Correo Regular (US Mail)

_____ **SIGNATURE / Firma**

_____ **DATE / Fecha**

DELTA DENTAL

www.deltadentalpr.com

ELECTRONIC DEBIT REQUEST FORM FOR INDIVIDUALS

ASEC 82294-00001 **Enrollment Date:** _____

Contact Information:

Individual Name: _____

Identification Number (Member ID): _____

Contact Person's Name:
(Parent **or Legal Guardian):** _____

Contact Person's Phone Number: _____

Fax Number: _____

Contact Person's E-mail Address: _____

Bank Information:

Bank Name: _____

Route & Transit Number (9 Digit Aba #) _____

Account Type: Check ☐ Savings ☐

Bank Account Number: _____

Transaction Date: 1st Day of the Month Monthly Rate: $ _____

Vendor Authorization:

_____ **X**_____ _____

Name – Parent or Legal Guardian | Signature | Date

Note: This authorization is to remain in full force and effect until Delta Dental of PR, Inc. receives a written notification from an authorized person, of any change to the information on this form. Also be advised that the transaction will be made on the date established, so if you have any change we must received the information before that day.

Please complete this form and include a CHECK or Money Order payable to Delta Dental for the payment of the first month of the policy. Also add a VOID CHECK of the account used to complete this form if the first payment is made with Money Order or with a Check of a different account.

There will be a charge fee of $15 dollars for each check or ACH transaction returned.

Delta Dental of Puerto Rico, Inc.
Metro Office Park
14 Calle 2 Suite 200
Guaynabo, PR 00968

Tel. (939) 205-3300
Fax. (787) 749-2600