



Delta Dental Plan of Massachusetts

ENROLLMENT FORM

PLEASE PRINT OR TYPE -

BE SURE FORM IS COMPLETED IN FULL TO ENSURE ENROLLMENT

P.O. BOX 9695
BOSTON, MASSACHUSETTS 02114
CORPORATE OFFICE (617) 896-1900 MA & NAT'L TOLL FREE (800) 451-1249
FAX (617) 896-1293

1 GROUP NAME		2 EFFECTIVE DATE		3 DATE OF HIRE		4 GROUP NUMBER	
5 SOCIAL SECURITY NO		6 LAST NAME (Subscriber)		7 FIRST NAME		8 DOB	9 SEX
10 HOME ADDRESS				11 CITY		12 STATE	13 ZIP

PLAN SELECTION

14. PLAN Select plan you are enrolling in:

- DeltaPremier** **DeltaPreferred** **DeltaCare**

If DeltaCare is selected, each subscriber & dependent must choose a DeltaCare Primary Care Dentist (PCD)

PLEASE LIST ALL DEPENDENT(S) COVERED UNDER YOUR POLICY

15. FIRST NAME	16. LAST NAME (IF DIFFERENT FROM SUBSCRIBER)	17. DATE OF BIRTH	18. SEX M/F	19. CHECK IF DEPENDENT IS OVER 19 AND A FULL TIME STUDENT	DELTACARE ONLY		
					20. CHOOSE A PCD FOR EACH COVERED INDIVIDUAL	21. PROVIDER #	22. DO YOU CURRENTLY USE THIS DENTIST?
SUBSCRIBER							
SPOUSE							
CHILDREN							

23. REASON FOR SUBMISSION (CHECK ONE)

- | | |
|--|--|
| <input type="checkbox"/> New Addition
<input type="checkbox"/> Individual <input type="checkbox"/> Individual + 1 <input type="checkbox"/> Family | <input type="checkbox"/> Status change (must be 1st of month)
<input type="checkbox"/> Individual to Family <input type="checkbox"/> Individual + 1 <input type="checkbox"/> Family to Individual |
| <input type="checkbox"/> Termination. Date of termination _____ | <input type="checkbox"/> Cobra - Reinstatement of subscriber |
| <input type="checkbox"/> Add dependent to family | <input type="checkbox"/> Cobra - new addition of dependent formerly covered under ID # _____ |
| <input type="checkbox"/> Reinstatement | Number of months Cobra eligible _____ |
| <input type="checkbox"/> Name / address change | <input type="checkbox"/> Cobra - reinstatement - transfer to Cobra sublocation |
| <input type="checkbox"/> Remove dependent from student status | |
| <input type="checkbox"/> Transfer from sublocation _____ to _____ | |

24. COORDINATION OF BENEFITS

Are you OR any other family member covered by another dental plan? No Yes

If YES, please indicate name of covered individual _____

OTHER DENTAL INSURANCE COMPANY	EMPLOYER NAME:	POLICY HOLDER ID NO.	EFFECTIVE DATE
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25 Are you OR any other family member covered by another medical plan? No Yes

If YES, please indicate name of covered individual _____

OTHER MEDICAL INSURANCE COMPANY	EMPLOYER NAME:	POLICY HOLDER ID NO	EFFECTIVE DATE
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I certify that all information is true and correct to the best of my knowledge. Also, I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Delta Dental Plan of Massachusetts. In addition, if my employer requires employee contributions for this coverage, I authorize the deductions of these amount from my wages

26 Subscriber Signature _____

_____ Date

Benefit Administrator Authorization _____

_____ Date