



# ENROLLMENT FORM

PLEASE PRINT OR TYPE -  
BE SURE FORM IS COMPLETED IN FULL TO ENSURE ENROLLMENT

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1. GROUP NAME: <i>Town of Walpole</i>		2. EFFECTIVE DATE:		3. DATE OF HIRE:		4. GROUP NUMBER: <i>8531-990</i>	
5. LAST NAME: (Subscriber)				6. FIRST NAME:			
7. SOCIAL SECURITY NO.:			8. DATE OF BIRTH:			9. GENDER: <b>F / M</b>	
10. HOME ADDRESS:			11. CITY:		12. STATE:	13. ZIP:	

### PLAN SELECTION

14. PLAN: Select plan you are enrolling in:

Delta Dental Premier    Delta Dental PPO    Delta Dental PPO Plus Premier    DeltaCare    The Value Plan

If DeltaCare or the Value Plan is selected, each subscriber & dependent must choose a DeltaCare Primary Care Dentist (PCD).

### PLEASE LIST ALL ELIGIBLE 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 OR VALUE PLAN 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)

- New Addition
  - Individual    Individual + 1    Family
- Termination
- Add dependent to family
- Reinstatement
- Remove dependent \_\_\_\_\_ name
- Name change
- Address change
- Remove dep. from student status \_\_\_\_\_ name
- Transfer from sublocation \_\_\_\_\_ to \_\_\_\_\_
- Status change
  - Individual to Family    Individual + 1    Family to Individual
- COBRA
  - Reinstatement of Subscriber
    - Individual    Individual + 1    Family
  - Transfer to COBRA Sublocation
  - New addition of dependent formerly covered under ID # \_\_\_\_\_

24. COORDINATION OF BENEFITS      If YES, please indicate name of covered individual:  
Are  you   OR    any other family member covered by another dental plan?    No    Yes \_\_\_\_\_

OTHER DENTAL INSURANCE CO.:	EMPLOYER NAME:	POLICY HOLDER ID NO.:	EFFECTIVE DATE
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25.      If YES, please indicate name of covered individual:  
Are  you   OR    any other family member covered by another medical plan?    No    Yes \_\_\_\_\_

OTHER MEDICAL INSURANCE CO.:	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 of Massachusetts. In addition, if my employer requires employee contributions for this coverage, I authorize the deduction of this amount from my wages.

26. Subscriber Signature

Date

Benefit Administrator Signature

Date