



ENROLLMENT FORM

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

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1. GROUP NAME:		2. EFFECTIVE DATE:		3. DATE OF HIRE:		4. GROUP NUMBER:	
5. LAST NAME: (Subscriber)				6. FIRST NAME:			
7. SOCIAL SECURITY NO.:			8. DATE OF BIRTH:			9. GENDER: F / M	
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)

- | | |
|--|--|
| <input type="checkbox"/> New Addition
<input type="checkbox"/> Individual <input type="checkbox"/> Individual + 1 <input type="checkbox"/> Family
<input type="checkbox"/> Termination
<input type="checkbox"/> Add dependent to family
<input type="checkbox"/> Reinstatement
<input type="checkbox"/> Remove dependent _____ name
<input type="checkbox"/> Name change
<input type="checkbox"/> Address change
<input type="checkbox"/> Remove dep. from student status _____ name | <input type="checkbox"/> Transfer from sublocation _____ to _____
<input type="checkbox"/> Status change
<input type="checkbox"/> Individual to Family <input type="checkbox"/> Individual + 1 <input type="checkbox"/> Family to Individual
COBRA
<input type="checkbox"/> Reinstatement of Subscriber
<input type="checkbox"/> Individual <input type="checkbox"/> Individual + 1 <input type="checkbox"/> Family
<input type="checkbox"/> Transfer to COBRA Sublocation
<input type="checkbox"/> 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
25. If YES, please indicate name of covered individual: Are <input type="checkbox"/> you OR <input type="checkbox"/> any other family member covered by another medical plan? <input type="checkbox"/> No <input type="checkbox"/> Yes _____			
OTHER MEDICAL INSURANCE CO.:	EMPLOYER NAME:	POLICY HOLDER ID NO.:	EFFECTIVE DATE

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