Print Form

DELTA DENTAL®

ENROLLMENT FORM

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

Delta Dental of Massachusetts
PO Box 9695
Boston, Massachusetts 02114
Customer Service (617) 886-1234 Toll Free (800) 872-0500
Corporate Office: (617) 886-1000 MA & Nat's Toll Free (800) 451-1249
Fax: (617) 886-1293 www.deltadentalma.com

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:

☐ **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**

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:

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:

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 Authorization _____ Date _____