



ENROLLMENT FORM

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

Delta Dental of Massachusetts
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Corporate Office: (617) 886-1000 MA & Nat's Toll Free (800) 451-1249
Fax: (617) 886-1293
www.deltamass.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
 DeltaPreferred Option Plus
 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	20. CHOOSE A PCD FOR EACH COVERED INDIVIDUAL		21. PROVIDER #	22. DO YOU CURRENTLY USE THIS DENTIST?
					DELTA CARE OR VALUE PLAN ONLY			
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:
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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 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 _____