



Delta Dental Plan of Massachusetts

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## ENROLLMENT FORM

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

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	DELTA CARE ONLY		22. DO YOU CURRENTLY USE THIS DENTIST?
					20. CHOOSE A PCD FOR EACH COVERED INDIVIDUAL	21. PROVIDER #	
SUBSCRIBER							
SPOUSE							
CHILDREN							

### 23. REASON FOR SUBMISSION (CHECK ONE)

- New Addition  
 Individual     Individual + 1     Family  
 Termination: Date of termination \_\_\_\_\_  
 Add dependent to family  
 Reinstatement  
 Name / address change  
 Remove dependent from student status  
 Transfer from sublocation \_\_\_\_\_ to \_\_\_\_\_
- Status change (must be 1st of month)  
 Individual to Family     Individual + 1     Family to Individual  
 Cobra - Reinstatement of subscriber  
 Cobra - new addition of dependent formerly covered under ID # \_\_\_\_\_  
 Number of months Cobra eligible \_\_\_\_\_  
 Cobra - reinstatement - transfer to Cobra sublocation

### 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