



Delta Dental Plan of Massachusetts

465 MEDFORD STREET
BOSTON, MASSACHUSETTS 02129-1454
CORPORATE OFFICE: (617) 886-1000
FAX: (617) 886-1293
MA & NAT'L TOLL FREE (800) 451-1249
www.deltamass.com

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

Table with columns: 15. FIRST NAME, 16. LAST NAME, 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? Rows include SUBSCRIBER, SPOUSE, CHILDREN.

23. REASON FOR SUBMISSION (CHECK ONE)

- New Addition Individual Individual + 1 Family Status change (must be 1st of month) Individual to Family Individual + 1 Family to Individual
Termination: Date of termination Add dependent to family Reinstatement Name / address change Remove dependent from student status Transfer from sublocation to
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

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 Plan of Massachusetts. In addition, if my employer requires employee contributions for this coverage, I authorize the deductions of these amount from my wages.

26. Subscriber Signature

Date

Benefit Administrator Authorization

Date