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
enrollment@deltadentalma.com

Customer Service (617) 886-1234
Corporate Office (617) 886-1000
Enrollment Fax (617) 886-1293

Toll Free (800) 872-0500
MA & Nat's Toll Free (800) 451-1249
www.deltadentalma.com


| 1. GROUP NAME: TOWN OF HOLLISTON | 2. EFFECTIVE DATE: | 3. DATE OF HIRE: | 4. GROUP NUMBER: 014633-7701 |
|---|---|---|---|
| 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** ☐ **Delta Dental EPO** ☐ **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+SP ☐ Individual+CH ☐ 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**

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 ☐ you OR ☐ any other family member covered by another medical plan? ☐ No ☐ 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 _____



SUBMIT TO DELTA DENTAL