



# 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  
Enrollment Fax (617) 886-1293

Toll Free (800) 872-0500

1. GROUP NAME*:	2. EFFECTIVE DATE*:	3. GROUP NUMBER*:			
4. LAST NAME* (Subscriber):			5. FIRST NAME*:		
6. SOCIAL SECURITY NO.*:			7. DATE OF BIRTH*:		8. GENDER*:
9. HOME ADDRESS*:			10. CITY*:	11. STATE*:	12. ZIP*:
13. HOME PHONE:		14. CELLULAR PHONE:		15. EMAIL:	

\*Required fields. If you do NOT fill these in, Delta Dental of Massachusetts will not be able to start up your coverage.

**PLEASE LIST ALL ELIGIBLE DEPENDENT(S) COVERED UNDER YOUR POLICY**

16. FIRST NAME	17. LAST NAME (If Different From Subscriber)	18. DATE OF BIRTH	19. GENDER
SPOUSE			
CHILDREN			

20. 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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21. 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. I agree to allow Delta Dental to communicate information to me related to my plan and dental health issues using the contact information provided. 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.

\_\_\_\_\_ Date\*      Benefit Administrator Authorization\*      Date\*

22. Subscriber Signature\*

\*Required fields.

**REASON FOR SUBMISSION (CHECK ONE)**

- |  |   |
|--|---|
| <input type="checkbox"/> New Addition                | <input type="checkbox"/> Transfer from sublocation _____ to _____ |
| <input type="checkbox"/> Termination                 | <input type="checkbox"/> Status change                            |
| <input type="checkbox"/> Reinstatement               | COBRA   |
| <input type="checkbox"/> Remove dependent _____ name | <input type="checkbox"/> Reinstatement of Subscriber              |
| <input type="checkbox"/> Name change                 | <input type="checkbox"/> Transfer to COBRA sublocation _____      |
| <input type="checkbox"/> Address change              |   |

