DELTA DENTAL

Delta Dental of Massachusetts
P.O. Box 9695
Boston, Massachusetts, 02114-9695

Customer Service: (617) 886-1234 Toll Free (800) 872-0500
Corporate Office: (617) 886-1000 MA & NAT'L Toll Free (800) 451-1249
Fax: (617) 886-1293 www.deltadentalma.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
Town of Brookline			00592

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:

☐ Plan 1: Low Option - Delta Dental PPO Plus Premier (Diagnostic & Preventive Services only)

☐ Plan 2: High Option - Delta Dental PPO Plus Premier (Comprehensive Plan)

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 FULL TIME STUDENT
SUBSCRIBER				
SPOUSE				
CHILDREN				

20. 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 to family ☐ Individual+1 ☐ Family to individual

____ Transfer to COBRA Sublocation _____

____ New addition of dependent formerly covered under ID#_____

21. 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 DAY

22. 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 DAY

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 contribution for this coverage, I authorize the deduction of this amount from my wages.

23. Subscriber Signature _____ Date _____ Benefit Administrator Authorization _____ Date _____