



Alternate Address Form

Please completely fill out the form to designate an alternate address for yourself, a spouse, or a covered dependent. The covered individuals listed in Section 2 will receive explanations of benefits, pre-treatment estimates, and ID Cards (if applicable) to the alternate address listed.

Check issues for visits to non-participating dentists will also be mailed to the alternate address with the explanation of benefits. Spouses and dependents over 18 are required to sign their own forms. Please attach any relevant legal documentation of dependents under 18.

Your Information	
Subscriber ID:	
Subscriber name:	
Alternate Address:	

Covered individuals for whom the alternate address should be used:

Please sign and date:

I have read the above statement and attest that I require plan communication including PHI to be sent to the alternate address indicated above.

Subscriber Signature

Date

Mail the completed form to:

Delta Dental of Massachusetts
P.O. Box 75688
Seattle, WA 98175

OR email to: enrollment@deltadentalma.com