

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

## Disabled Dependent Application

Please fill this form to request eligibility for an overage dependent with a qualifying disability.

|   |   |               |   |
|---|---|---------------|---|
| 1. SUBSCRIBER NAME  |   |               |   |
| FIRST   |   | LAST          |   |
| 2. SUBSCRIBER ID NUMBER   | 3. GROUP NUMBER   | 4. GROUP NAME |   |
| 5. ADDRESS (Number, Street, City, State and Zip Code)   |   |               |   |
| 6. FULL NAME OF DEPENDENT   | 7. DEPENDENT'S DATE OF BIRTH  |               | 8. DATE DEPENDENT'S DISABILITY OCCURRED   |
|   | Month   | Date          | Year  |
| 9. IS DEPENDENT PERMANENTLY RESIDING IN YOUR HOUSEHOLD? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "NO", EXPLAIN:  |   |               |   |
| 10. IS THE DEPENDENT UPON YOU FOR SUPPORT?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 11. IF "YES", WHAT PART OF SUPPORT DO YOU CONTRIBUTE?   |               | 12. IS THE DEPENDENT LISTED AS A DEPENDENT IN YOUR LAST FEDERAL INCOME TAX STATEMENT?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. NAME AND ADDRESS OF PHYSICIAN WHO ATTENDED DEPENDENT.   |   |               |   |
| <p>I have read the foregoing statements and answers and declare them to be true and complete to the best of my knowledge and belief. To the extent permitted by statute, I hereby authorize any physician or other person who has attended my above named dependent child or who may hereafter attend or examine such child to disclose any knowledge or information thereby acquired by him. A photostat of this authorization shall be valid as the original.</p> |   |               |   |
| _____   |   | _____         |   |
| SIGNATURE OF SUBSCRIBER   |   | DATE          |   |
| <p><b>Mail form to: Delta Dental of Massachusetts</b><br/>         P.O. Box 75688<br/>         Seattle, WA 98175</p> <p><b>Or email to: enrollment@deltadentalma.com</b></p>  |   |               |   |
| <b>TO BE COMPLETED BY ATTENDING PHYSICIAN</b>   |   |               |   |
| 1. IS CHILD NOW INCAPABLE OF SELF-SUPPORT BECAUSE OF A DISABILITY?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 2. HAS SUCH DISABILITY EXISTED CONTINUOUSLY SINCE BEFORE CHILD ATTAINED AGE 19?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |               | 3. PROGNOSIS (Estimate months or years)   |
| 4. NATURE OF DISABILITY (Please give as much detail as practicable)   |   |               |   |
| _____   |   | _____         |   |
| SIGNATURE OF PHYSICIAN  |   | DATE          |   |