DELTA DENTAL®

Customer Service: 800-872-0500
Email: enrollment@deltadentalma.com

Delta Dental of Massachusetts
PO Box 75688
Seattle, WA 98175

Delta Dental Enrollment Form

BE SURE FORM IS COMPLETED TO ENSURE ENROLLMENT

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:

21. Are ☐ you OR ☐ any other family member covered by another medical plan? ☐ No ☐ Yes

If YES, please indicate name of covered individual _____ _____.

OTH ER MEDICAL INSURANCE COMPANY:	EMPLOYER NAME:	POLICY HOLDER ID NO.:	EFFECTIVE DATE:

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 Massach usetts. In addition, if my employer requires employee contributions for this coverage, I authorize the deduction of this amount from my wages.

_____ _____ _____ _____

22. Subscriber Signature* Date* Benefit Administrator Authorization* Date*

*Required fields.

REASON FOR SUBMISSION (CHECK ONE)

- ☐ New Addition
- ☐ Termination
- ☐ Reinstatement
- ☐ Remove dependent _____ name
- ☐ Name change
- ☐ Address change
- ☐ Transfer from sublocation _____ to _____
- ☐ Status change

COBRA

- ☐ Reinstatement of Subscriber
- ☐ Transfer to COBRA sublocation _____

Mail the completed form to: Delta Dental of Massachusetts, PO Box 75688, Seattle, WA 98175 or email to: enrollment@deltadentalma.com