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
Corporate Office (617) 886-1000
Fax (617) 886-1293

Toll Free (800) 872-0500
MA & Nat's Toll Free (800) 451-1249
www.deltadentalma.com

1. GROUP NAME: Town of Swampscott	2. EFFECTIVE DATE:	3. DATE OF HIRE:	4. GROUP NUMBER: 009508-9285
5. LAST NAME: (Subscriber)		6. FIRST NAME:	
7. SOCIAL SECURITY NO.:	8. DATE OF BIRTH:	9. GENDER: F / M	
10. HOME ADDRESS:	11. CITY:	12. STATE:	13. ZIP:

PLAN SELECTION

14. PLAN: Select plan you are enrolling in:

☐ **Delta Dental Premier** ☐ **Delta Dental PPO** ☒ **Delta Dental PPO *Plus Premier*** ☐ **DeltaCare** ☐ **The Value Plan**

If DeltaCare or the Value Plan is selected, each subscriber & dependent must choose a DeltaCare Primary Care Dentist (PCD).

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 A FULL TIME STUDENT	DELTACARE OR VALUE PLAN ONLY: 20. CHOOSE A PCD FOR EACH COVERED INDIVIDUAL	21. PROVIDER #	22. DO YOU CURRENTLY USE THIS DENTIST
SUBSCRIBER							
SPOUSE							
CHILDREN							

23. 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 ☐ Individual + 1 ☐ Family
☐ Transfer to COBRA Sublocation
☐ New addition of dependent formerly covered under ID # _____

24. COORDINATION OF BENEFITS

If YES, please indicate name of covered individual:

Are ☐ you OR ☐ any other family member covered by another dental plan? ☐ No ☐ Yes _____

OTHER DENTAL INSURANCE CO.:	EMPLOYER NAME:	POLICY HOLDER ID NO.:	EFFECTIVE DATE

25.

If YES, please indicate name of covered individual:

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

OTHER MEDICAL INSURANCE CO.:	EMPLOYER NAME:	POLICY HOLDER ID NO.:	EFFECTIVE DATE

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

_____ _____ _____ _____

26. Subscriber Signature | Date | Benefit Administrator Signature | Date

SUBMIT TO DELTA DENTAL