



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

Form with fields for personal information: 1. SOCIAL SECURITY NO.\*, 2. LAST NAME\*, 3. MIDDLE INITIAL, 4. FIRST NAME\*, 5. DATE OF BIRTH\*, 6. GENDER, 7. SUBGROUP NUMBER (10 digits)\*, 8. SUBGROUP NAME\*, 9. EFFECTIVE DATE\* (MM/DD/CCYY), 10. HOME ADDRESS\*, 11. CITY\*, 12. STATE\*, 13. ZIP\*, 14. HOME PHONE, 15. CELLULAR PHONE, 16. WORK PHONE, 17. EMAIL ADDRESS, 18. RACE, 19. LANGUAGE.

\* THIS FIELD IS REQUIRED

PLAN SELECTION

20. 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 & dependant must choose a DeltaCare Primary Care Dentist (PCD)

PLEASE LIST ALL ELIGIBLE DEPENDENT(S) COVERED UNDER YOUR POLICY

Table with columns for dependent information: 21. FIRST NAME, 22. LAST NAME, 23. DATE OF BIRTH (MM/DD/CCYY), 24. GENDER M/F, 25. FULL TIME STUDENT Y/N, 26. FACILITY # (DELTACARE), 27. CHOOSE A PCD FOR EACH COVERED INDIVIDUAL, 28. PROVIDER #, 29. DO YOU CURRENTLY USE THIS DENTIST.

30. REASON FOR SUBMISSION (CHECK ONE)

NEW ADD TERMINATION DEMOGRAPHIC CHANGE SUBGROUP TRANSFER

SUBSCRIBER SIGNATURE DATE

BENEFIT ADMINISTRATOR AUTHORIZATION DATE