DELTA DENTAL®

ENROLLMENT FORM

PLEASE PRINT OR TYPE -
BE SURE FORM IS COMPLETED IN FULL TO ENSURE ENROLLMENT

Delta Dental of Massachusetts
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Boston, Massachusetts, 02114-9695

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Corporate Office: (617) 886-1000 MA & NAT'L Toll Free (800) 451-1249
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1. GROUP NAME:	2. EFFECTIVE DATE:	3. DATE OF HIRE:	4. GROUP NUMBER
City of Westfield			007096-99_ _

5. SOCIAL SECURITY NO.	6. LAST NAME (Subscriber)	7. FIRST NAME:	8. DOB:	9. SEX:

10. HOME ADDRESS:	11: CITY:	12. STATE:	13. ZIP

PLAN SELECTION

14. PLAN: Select plan you are enrolling in:

☐ **Delta Dental PPO Plus Premier - Low Plan**

☐ **Delta Dental PPO Plus Premier - High Plan**

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	
SUBSCRIBER				
SPOUSE				
CHILDREN				

20. REASON FOR SUBMISSION (CHECK ONE)

☐ New Addition
- ☐ Individual ☐ 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 ☐ Family to individual

☐ COBRA
☐ Reinstatement of Subscriber
- ☐ Individual to family ☐ Family to individual

Transfer to COBRA Sublocation _____
New addition of dependent formerly covered under ID#_____

21. 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 DAY

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

If YES, please indicate name of covered individual _____ .

OTHER MEDICAL INSURANCE COMPANY:	EMPLOYER NAME:	POLICY HOLDER ID NO.:	EFFECTIVE DAY

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

24. Subscriber Signature _____ Date _____ Benefit Administrator Authorization _____ Date _____