



Enrollment Form

Delta Dental of Massachusetts

P.O. Box 9695

Boston, MA 02114-9695

Customer Service: 617-886-1234 Toll Free

(800) 872-0500

Corporate Office: 617-886-1000 MA & NATL Toll Free

(800) 451-1249

Fax Number: 617-886-1293 WWW.Deltadentalma.com

PLEASE PRINT OR TYPE – BE SURE FORM IS COMPLETE IN FULL TO ENSURE ENROLLMENT

Group Number: 012314-		Group Name: Town of Arlington				
1. Employee Last Name	2. First Name	3. Social Security No.	4. Date of Birth	5. Marital Status		
				Single	Married	Divorced
6. Home Address		7. City	8. State	9. Zip Code	10. Hire Date	11. Effective Date
PLAN SELECTION						
12. Plan: Select dental plan you are enrolling in:			Please check off sub-location:			
<input type="checkbox"/> Plan 1: Low Option Delta PPO Plus Premier Voluntary - <input type="checkbox"/> Active 9904 <input type="checkbox"/> Retire 9905 <input type="checkbox"/> Cobra 9906 \$40.19 Ind / \$94.35 Family						
<input type="checkbox"/> Plan 2: High Option Delta PPO Plus Premier Voluntary - <input type="checkbox"/> Active 9901 <input type="checkbox"/> Retire 9902 <input type="checkbox"/> Cobra 9903 \$55.72 Ind / \$130.80 Family						
PLEASE LIST ALL ELIGIBLE DEPENDENTS COVERED UNDER YOUR DENTAL POLICY						
13. First Name	14. Last Name	15. Date of Birth	16. Sex (M/F)	17. Check if dependent is over 19 and full time student		
Spouse						
Children						
18. Reason for Submission:						
<input type="checkbox"/> New Addition- <input type="checkbox"/> Individual <input type="checkbox"/> Individual +1 <input type="checkbox"/> Family <input type="checkbox"/> Status Change- <input type="checkbox"/> Individual <input type="checkbox"/> Individual +1 <input type="checkbox"/> Family <input type="checkbox"/> Termination <input type="checkbox"/> COBRA- <input type="checkbox"/> Low Plan 9906 <input type="checkbox"/> High Plan 9903 <input type="checkbox"/> Demographic Change <input type="checkbox"/> Subgroup Transfer						
19. Coordination of Benefits:						
Are <input type="checkbox"/> You or <input type="checkbox"/> Any other family member covered by another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If yes, please indicate name of covered individuals:						

I CERTIFIED 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 TERMINATED BY MY EMPLOYER OR PLAN SPONSOR. IF MY EMPLOYER OR PLAN SPONSOR REQUIRED EMPLOYEE CONTRIBUTIONS FOR THIS COVERAGE I AUTHORIZED THE DEDUCTIONS OF THESE AMOUNTS FROM MY WAGES ON A PRETAX BASIS. I UNDERSTAND THAT MY DEPENDENTS MUST REMAIN ENROLLED AND BE DROPPED ONLY DURING CONTRACT REOPENING, EXCEPT IN THE EVENT OF FAMILY STATUS CHANGE.

Subscriber Signature

Date

Benefit Administrator Authorization

Date