DELTA DENTAL

Delta Dental of Massachusetts
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ENROLLMENT FORM

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

1. GROUP NAME:	2. EFFECTIVE DATE	3. GROUP NUMBER
MIT Retiree Dental Plan		000444-9901

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

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

PLAN SELECTION

13. PLAN: Select plan you are enrolling in:

☐ Delta Dental Premier ☐ Delta Dental PPO ☐ Delta Dental PPO *Plus Premier* ☐ Delta Dental PPO Value

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

14. FIRST NAME	15. LAST NAME: (IF DIFFERENT FROM SUBSCRIBER)	16. DATE OF BIRTH	17. SEX M/F	18. CHECK IF DEPENDENT IS OVER 19 AND FULL TIME STUDENT
SUBSCRIBER				
SPOUSE				
CHILDREN				

19. 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 to family ☐ Individual+1 ☐ Family to individual
- ____ Transfer to COBRA Sublocation _____
- ____ New addition of dependent formerly covered under ID#_____

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 DAY

21. 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.

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