



# ENROLLMENT FORM

Delta Dental of Massachusetts  
P.O. Box 9695  
Boston, Massachusetts, 02114-9695

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

Customer Service: (617) 886-1234 Toll Free (800) 872-0500  
Corporate Office: (617) 886-1000 MA & NAT'L Toll Free (800) 451-1249  
Fax: (617) 886-1293 www.deltadentalma.com

1. GROUP NAME: Town of Brookline		2. EFFECTIVE DATE:	3. DATE OF HIRE:	4. GROUP NUMBER	
5. SOCIAL SECURITY NO.	6. LAST NAME (Subscriber)		7. FIRST NAME:		8. DOB:
10. HOME ADDRESS:			11. CITY:	12. STATE:	13. ZIP

## PLAN SELECTION

14. PLAN: Select plan you are enrolling in:

- Plan 1: Low Option - Delta Dental PPO Plus Premier (Diagnostic & Preventive Services only)
- Plan 2: High Option - Delta Dental PPO Plus Premier (Comprehensive 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	19. CHECK IF DEPENDENT IS OVER 19 AND FULL TIME STUDENT
SUBSCRIBER				
SPOUSE				
CHILDREN				

## 20. 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# \_\_\_\_\_

## 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
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22. 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
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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.

23. Subscriber Signature \_\_\_\_\_

Date \_\_\_\_\_

Benefit Administrator Authorization \_\_\_\_\_

Date \_\_\_\_\_