



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

1. SOCIAL SECURITY NO.*	2. LAST NAME*	3. MIDDLE INITIAL	4. FIRST NAME*	5. DATE OF BIRTH* (MM/DD/CCYY)
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

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)	DELTACARE OR VALUE PLAN ONLY		
						27. CHOOSE A PCD FOR EACH COVERED INDIVIDUAL	28. PROVIDER #	29. DO YOU CURRENTLY USE THIS DENTIST
SPOUSE								
CHILDREN								

30. REASON FOR SUBMISSION (CHECK ONE)

- NEW ADD**
 TERMINATION
 DEMOGRAPHIC CHANGE
 SUBGROUP TRANSFER

 SUBSCRIBER SIGNATURE DATE

 BENEFIT ADMINISTRATOR AUTHORIZATION DATE