DELTA DENTAL®

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)
	0095066369	Diocese of Worcester	

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 _____