DELTA DENTAL

ENROLLMENT FORM

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

HSA
135 Wood Road
Braintree, MA 02184
Tel.: 800-696-8167
Fax: 781-848-7020

1. GROUP NAME: HSA	2. EFFECTIVE DATE	3. DATE OF HIRE	4. GROUP NUMBER 4784-

5. SOCIAL SECURITY NO.	6. LAST NAME (Subscriber)	7. FIRST NAME:	8. DOB:	9. SEX:

10. HOME ADDRESS:	11: CITY:	12. STATE:	13. ZIP

14. COMPANY NAME:	15. WORK PHONE:	16. HOME

PLAN SELECTION

17. PLAN

☐ Delta Dental Premier — 2+ emplyees, No Waiting Period
☐ Delta Dental Premier — 10+ employees, No Waiting Period
☐ Delta Care II — 2+ emplyees, No Waiting Period
☐ Delta Dental Total Choice PPO — 2+ emplyees, No Waiting Period

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

18. FIRST NAME	19. LAST NAME: (IF DIFFERENT FROM SUBSCRIBER)	20. DATE OF BIRTH	21. SEX M/F	22. CHECK IF DEPENDENT IS OVER 19 AND FULL TIME STUDENT	23. DELTACARE MEMBERS ONLY		
					Choose Provider for each covered individual	Porvider No.	Do you currenlty use this dentist?
SUBSCRIBER				☐			
SPOUSE				☐			
CHILDREN				☐			
				☐			
				☐			
				☐			

24. REASON FOR SUBMISSION (CHECK ONE)

☐ New Addition
  ☐ Individual ☐ 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 ☐ Family
☐ COBRA
  Reinstatement of Subscriber
  ☐ Individual ☐ Individual+1 ☐ Family
  ☐ Transfer to COBRA Sublocation _____
  ☐ New addition of dependent formerly covered under ID#_____

25. 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

26. 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.

Subscriber Signature _____ Date _____ Benefit Administrator Authorization _____ Date _____