DELTA DENTAL

HSA PLAN ENROLLMENT FORM

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

Delta Dental of Massachusetts

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Health Services Administrators
135 Wood Rd
Braintree, MA 02184-2501

Phone: (800) 696-8167
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1. GROUP NAME	2. EFFECTIVE DATE	3. DATE OF HIRE	4. GROUP NUMBER	5. WORK PHONE

6. SOCIAL SECURITY NO.	7. LAST NAME (Subscriber)	8. FIRST NAME	9. DOB	10. SEX	11. COMPANY NAME

12. HOME ADDRESS	13. HOME PHONE	14. CITY	15. STATE	16. ZIP

PLAN SELECTION

17. PLAN: Select plan you are enrolling in:

☐ Delta Dental Adult Pediatric ☐ Delta Dental EPO Exclusive Network Plan
☐ Delta Dental EPO Pediatric ☐ Delta Dental EPO Pediatric Basic ☐ Delta Dental Premier Pediatric ☐ Delta Dental PPO Pediatric
☐ Delta Dental Premier Family Enhanced ☐ Delta Dental Premier Family Value ☐ Delta Dental EPO Family Enhanced ☐ Delta Dental EPO Family
☐ Delta Dental PPO Plus Premier (2+) No EHB ☐ Delta Dental PPO Plus Premier (2+) Standard EHB ☐ Delta Dental PPO Plus Premier (2+) Enhanced EHB
☐ Delta Dental PPO Plus Premier (10+) No EHB ☐ Delta Dental PPO Plus Premier (10+) Standard EHB ☐ Delta Dental PPO Plus Premier (10+) Enhanced EHB

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. Please check here if each dependent listed below is to be enrolled in their own pediatric policy. Please include each dependents respective social security number for enrollment in their own policy.		23. PLEASE A INDICATE IF EFFECTIVE DATE IS DIFFERENT	24. EFFECTIVE DATE
SUBSCRIBER							
SPOUSE				☐	SSN:	☐	
DEPENDENT				☐	SSN:	☐	
				☐	SSN:	☐	
				☐	SSN:	☐	
				☐	SSN:	☐	

25. REASON FOR SUBMISSION (CHECK ONE)

☐ New Addition
☐ Individual ☐ Individual+SP ☐ Individual+CH ☐ 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 ☐ Individual+SP ☐ Individual+CH ☐ Family

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

26. 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

27. 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.

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