



# ENROLLMENT FORM

PLEASE PRINT OR TYPE -

BE SURE FORM IS COMPLETED IN FULL TO ENSURE ENROLLMENT

Delta Dental of Massachusetts  
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MA & Nat's Toll Free (800) 451-1249  
www.deltadentalma.com

1. GROUP NAME: <b>City of Gloucester</b>		2. EFFECTIVE DATE:		3. DATE OF HIRE:		4. GROUP NUMBER: <b>013690</b>	
5. LAST NAME (Subscriber)				6. FIRST NAME:			
7. SOCIAL SECURITY NO.:			8. DATE OF BIRTH:			9. GENDER: <b>F / M</b>	
10. HOME ADDRESS:			11. CITY:		12. STATE:	13. ZIP:	

### PLAN SELECTION

14. PLAN: Select plan you are enrolling in:

- Delta Dental Premier **High Opt.**
 Delta Dental PPO **Low Opt.**
 Delta Dental PPO Plus Premier
  Delta Dental EPO
  DeltaCare
  The Value Plan

If DeltaCare or the Value Plan is selected, each subscriber & dependent must choose a DeltaCare Primary Care Dentist (PCD).

### 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 A FULL TIME STUDENT	DELTACARE OR VALUE PLAN ONLY		
					20. CHOOSE A PCD FOR EACH COVERED INDIVIDUAL	21. PROVIDER #	22. DO YOU CURRENTLY USE THIS DENTIST
SUBSCRIBER							
SPOUSE							
CHILDREN							

### 23. 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 to Family  Individual + 1  Family to Individual  
 COBRA  
 Reinstatement of Subscriber  
 Individual  Individual + 1  Family  
 Transfer to COBRA Sublocation  
 New addition of dependent formerly covered under ID # \_\_\_\_\_

24. COORDINATION OF BENEFITS If YES, please indicate name of covered individual:  
Are  you OR  any other family member covered by another dental plan?  No  Yes \_\_\_\_\_

OTHER DENTAL INSURANCE CO.:	EMPLOYER NAME:	POLICY HOLDER ID NO.:	EFFECTIVE DATE
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25. If YES, please indicate name of covered individual:  
Are  you OR  any other family member covered by another medical plan?  No  Yes \_\_\_\_\_

OTHER MEDICAL INSURANCE CO.:	EMPLOYER NAME:	POLICY HOLDER ID NO.:	EFFECTIVE DATE
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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 contributions for this coverage, I authorize the deduction of this amount from my wages.

26. Subscriber Signature

Date

Benefit Administrator Signature

Date