# Delta Dental PPO℠ Plus Premier 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

Customer Service (617) 886-1234
Enrollment Fax (617) 886-1293
Toll Free (800) 872-0500
MA & Nat's Toll Free (800) 451-1249

TOWN OF NEEDHAM ☐ School Employee ☐ Town Employee

| 1. GROUP NAME*: Town of Needham | 2. EFFECTIVE DATE*: | 3.GROUP NUMBER*: (Please select one) ☐ Low Plan (#010815-9901) or ☐ High Plan (#010815-9902) | |
|---|---|---|---|
| 4. LAST NAME*: (Subscriber) | | 5. FIRST NAME*: | |
| 6. SOCIAL SECURITY NO.*: | | 7. DATE OF BIRTH*: | 8. GENDER*: |
| 9. HOME ADDRESS*: | | 10. CITY*: | 11. STATE*: / 12. ZIP*: |
| 13. HOME PHONE: | 14. CELLULAR PHONE: | 15. EMAIL: | |

*Required fields. If you do NOT fill these in, Delta Dental of Massachusetts will not be able to start up your coverage.

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

| 16. FIRST NAME | 17. LAST NAME (If Different From Subscriber) | 18. DATE OF BIRTH | 19. GENDER |
|---|---|---|---|
| SUBSCRIBER | | | |
| SPOUSE | | | |
| CHILDREN | | | |
| | | | |
| | | | |
| | | | |
| | | | |

20. 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 DATE: |
|---|---|---|---|
| | | | |

21. 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 DATE: |
|---|---|---|---|
| | | | |

I certify that all information is true and correct to the best of my knowledge. I agree to allow Delta Dental to communicate information to me related to my plan using the contact information provided. 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.

_____ _____ _____ _____

22. Subscriber Signature* Date* Benefit Administrator Authorization* Date*

*Required fields.

**REASON FOR SUBMISSION (CHECK ONE)**

- ☐ New Addition
- ☐ Termination
- ☐ Reinstatement
- ☐ Remove dependent _____ name
- ☐ Name change
- ☐ Address change
- ☐ Transfer from sublocation _____ to _____
- ☐ Status change

COBRA

- ☐ Reinstatement of Subscriber
- ☐ Transfer to COBRA sublocation _____