Delta Dental PPO℠ Plus Premier Enrollment Form

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

Fund Office Phone (617) 354-1110 Email Address info@cdvfund.org
Fund Office Fax (617) 354-3315 Website www.cdvfund.org

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

1. GROUP NAME*:	2. EFFECTIVE DATE*:	3. GROUP NUMBER*:
4. LASTNAME*: (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:

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

**Dependent Children ages 19 to under 26 must complete a dependent children enrollment application (age 19 – under 26)*

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* ____________

REASON FOR SUBMISSION (CHECK ONE)

- ☐ New Addition
  - ☐ Individual ☐ Individual + 1 ☐ Family
- ☐ Termination
- ☐ Reinstatement
- ☐ Remove Dependent________________________name
- ☐ Add Dependent(s)
- ☐ Name Change
- ☐ Address Change
- ☐ Transfer from sublocation________________to________________
- ☐ Status Change
  - ☐ Individual to Family ☐ Individual + 1
  - ☐ Family to Individual
- ☐ **COBRA**
  - ☐ Reinstatement of Subscriber
  - ☐ Transfer to COBRA sublocation ________________________