DELTA DENTAL®

CAMBRIDGE PUBLIC EMPLOYEES DENTAL & VISION FUND

DELTA DENTAL PPO PLUS PREMIER ENROLLMENT/CHANGE FORM

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

GROUP INFORMATION: TO BE COMPLETED BY EMPLOYER

1. GROUP NAME:	2. EFFECTIVE DATE:	3. GROUP NUMBER:

SUBSCRIBER INFORMATION: TO BE COMPLETED BY EMPLOYEE

4. LASTNAME		5. FIRST NAME	
6. SOCIAL SECURITY	7. DATE OF BIRTH	8. GENDER	9. MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED
10. HOME ADDRESS		11. CITY	12. STATE / 13. ZIP CODE
14. PRIMARY PHONE	15. SECONDARY PHONE	16. EMAIL ADDRESS	

ENROLLMENT OR CHANGE REQUEST

17. **ENROLLMENT/CHANGE REQUESTED FOR:**
☐ SUBSCRIBER ☐ SPOUSE/EX-SPOUSE ☐ DEPENDENT CHILD/CHILDREN

18. **COVERAGE TYPE:**
☐ INDIVIDUAL ☐ INDIVIDUAL + 1 ☐ FAMILY

19. **REASON FOR CHANGE:**
☐ NEW ENROLLMENT(S) ☐ REINSTATMENT ☐ COBRA ☐ ADD SPOUSE ☐ ADD DEPENDENT CHILD/CHILDREN

☐ TERMINATION (SUBSCRIBER) ☐ REMOVE SPOUSE/EX-SPOUSE ☐ REMOVE DEPENDENT CHILD/CHILDREN

☐ DEPARTMENT CHANGE TO:_____ ☐ SUBLOCATION CHANGE TO:_____

INFORMATION CHANGE: ☐ ADDRESS CHANGE ☐ NAME CHANGE ☐ GENDER CHANGE ☐ DOB CHANGE ☐ OTHER

IF NAME CHANGE (PREVIOUS NAME): _____

IF OTHER CHANGE (EXPLAIN): _____

DEPENDENT INFORMATION: (Do not complete this section if **Subscriber Only Coverage**).

List only eligible dependent(s) to be covered under this plan, removed, or affected by any changes. Dependent children between the ages 19-26 & claimed on subscriber taxes – must complete age 19-26 dependent affidavit or are full-time students ages 19-25 – must submit a full-time student verification status or permanently disabled – must complete a disabled dependent application to be eligible.

20. FIRST NAME	21. LAST NAME	22. DATE OF BIRTH	23. GENDER	24. ADD/ REMOVE	
SPOUSE				ADD	
				REMOVE	
CHILDREN				ADD	
				REMOVE	
				ADD	
				REMOVE	
				ADD	
				REMOVE	
				ADD	
				REMOVE	
				ADD	
				REMOVE	

COORDINATION OF BENEFITS

25. ARE ☐ YOU OR ☐ ANY OTHER FAMILY MEMBER COVERED BY ANOTHER DENTAL PLAN? ☐ YES OR ☐ NO

IF YES COVERED INDIVIDUAL: _____ POLICY HOLDER ID #:_____

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 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 the amount from my wages. **By signing below, I hereby accept coverage**.

SUBSCRIBER SIGNATURE:_____ DATE: _____

Dental & Vision Administrator(s) Use Only:

BENEFIT ADMINISTRATOR **AUTHORIZATION**:_____ DATE: _____