Enrollment Form

Delta Dental of Massachusetts
P.O. Box 9695
Boston, MA 02114-9695
Customer Service: 617-886-1234 Toll Free (800) 872-0500
Corporate Office: 617-886-1000 MA & NATL Toll Free (800) 451-1249
Fax Number: 617-886-1293 WWW.Deltadentalma.com

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

Group Number: 012314-		Group Name: Town of Arlington			
1. Employee Last Name	2. First Name	3. Social Security No.	4. Date of Birth	5. Marital Status Single Married Divorced	
6. Home Address		7. City	8. State / 9. Zip Code	10. Hire Date	11. Effective Date

PLAN SELECTION

12. Plan: Select dental plan you are enrolling in: Please check off sub-location:

() Plan 1: Low Option Delta PPO Plus Premier Voluntary - $42.20/$99.07 () Active 9904 () Retire 9905 () Cobra 9906

() Plan 2: High Option Delta PPO Plus Premier Voluntary - $58.51/$137.34 () Active 9901 () Retire 9902 () Cobra 9903

PLEASE LIST ALL ELIGIBLE DEPENDENTS COVERED UNDER YOUR DENTAL POLICY

13. First Name	14. Last Name	15. Date of Birth	16. Sex (M/F)	17. Check if dependent is over 19 and full time student
Spouse				
Children				

18. **Reason for Submission:**

__ New Addition- __Individual __Family __ Status Change- __Individual __Individual +1 __Family

__ Termination __ COBRA- __Low Plan 9906 __High Plan 9903

__ Demographic Change

__ Subgroup Transfer

19. **Coordination of Benefits:**

Are __ You or __ Any other family member covered by another dental plan? __Yes __ No

If yes, please indicate name of covered individuals:

I CERTIFIED 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 TERMINDATED BY MY EMPLOYER OR PLAN SPONSOR. IF MY EMPLOYER OF PLAN SPONSOR REQUIRED EMPLOYEE CONTRIBUTIONS FOR THIS COVERAGE I AUTHORIZED THE DEDUCTIONS OF THESE AMOUNTS FROM MY WAGES ON A PRETAX BASIS. I UNDERSTAND THAT MY DEPENDENTS MUST REMAIN ENROLLED AND BE DROPPED ONLY DURING CONTRACT REOPENING, EXCEP IN THE EVENT OF FAMILY STATUS CHANGE.

_____ _____ _____ _____

Subscriber Signature Date Benefit Administrator Authorization Date