Application and Change Form for Delta Dental Individual and Family

P.O. Box 9695
Boston, Massachusetts 02114-9695

Customer Service: (800) 872-0500
www.deltadentalma.com/dental_plans/individual.asp

Please print or type. Required fields are starred (*) and must be completed to ensure enrollment. Subscriber must be age 18 or older:

1. *LAST NAME: (Subscriber)	2. MIDDLE INITIAL: (Optional)	3. * FIRST NAME	
4. *SOCIAL SECURITY NO:	5. *DATE OF BIRTH:	6. *GENDER: F / M	
7. *HOME ADDRESS:	8. *CITY:	9. *STATE:	10. *ZIP:
11. BILLING ADDRESS: (If different)	12. CITY:	13. STATE:	14. ZIP:
15. *COUNTY:	16. *PHONE NUMBER:	17. *E-MAIL:	

ELIGIBLE DEPENDENT(S) TO BE COVERED UNDER THIS POLICY

If you are applying for **Subscriber Only** coverage, do not complete this section

18. FIRST NAME*	19. MIDDLE INITIAL (optional)	20. LAST NAME* (if different from subscriber)	21. DATE OF BIRTH*	22. SOCIAL SECURITY NUMBER	23. GENDER* M/F	DELTACARE PLAN ONLY		
						24. CHOOSE A PCD FOR EACH COVERED INDIVIDUAL	25. PROVIDER #	26. DO YOU CURRENTLY USE THIS DENTIST?
Subscriber								
Spouse								
Children								

27. Are you a former Delta Dental of Massachusetts member through an Employer plan or COBRA? ☐ No ☐ Yes
If yes, please provide former subscriber ID Number ______ Last Date of Coverage ______

REASON FOR SUBMISSION

28. * CHECK ONE:
☐ New Application ☐ Reinstatement ☐ Termination ☐ Change

IF TERMINATION OR CHANGE, PLEASE COMPLETE BELOW (CHECK ALL THAT APPLY):

☐ Name ______ Phone Number ______
☐ Address ______ Email ______
☐ Coverage to: ☐ Subscriber Only ☐ Subscriber+One ☐ Family
☐ Add Dependent(s) Name ______ Name ______
☐ Remove Dependent(s) Name ______ Name ______

Please use a separate page for additional dependents to be added or removed from plan.

☐ If changing plans indicate new selection: ☐ Delta Dental Individual and Family Premier Option 1 ☐ Delta Dental Individual and Family Premier Option 2 ☐ Delta Dental Individual and Family PPO *Value for Seniors* ☐ Delta Dental Individual and Family EPO ☐ DeltaCare

Termination (Reason):
☐ Relocated out of Massachusetts ☐ Have other Dental Plan ☐ Other ______ ☐ Non-Payment ☐ Deceased

DELTA DENTAL PLANS SELECTION

Please refer to the Summary Plan description to review your options

29. *SELECT ONE: ☐ Delta Dental Individual and Family Premier Option 1 ☐ Delta Dental Individual and Family Premier Option 2 ☐ Delta Dental Individual and Family PPO *Value for Seniors*
☐ Delta Dental Individual and Family EPO ($50 Deductible, $1000 Annual Maximum, 100%/70%/40% Coinsurance) ☐ DeltaCare

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

30. *SELECT ONE: ☐ Age 50 and older ☐ Under age 50

Delta Dental of Massachusetts PPO and Premier insurance products are offered by Dental Service of Massachusetts, Inc.
Delta Dental of Massachusetts EPO and DeltaCare insurance products are offered by DSM Massachusetts Insurance Company, Inc.

To complete this application, you must review the information on page 2, sign in section 31 and mail items to Delta Dental of Massachusetts, P.O. Box 9695, Boston, MA, 02114