



# ENROLLMENT FORM

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

Delta Dental of Massachusetts  
P.O. Box 9695  
Boston, Massachusetts, 02114-9695

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Corporate Office: (617) 886-1000 MA & NAT'L Toll Free (800) 451-1249  
Fax: (617) 886-1293 www.deltadentalma.com

1. GROUP NAME: <b>City of Westfield</b>		2. EFFECTIVE DATE:		3. DATE OF HIRE:		4. GROUP NUMBER <b>007096-99__</b>	
5. SOCIAL SECURITY NO.:		6. LAST NAME (Subscriber)		7. FIRST NAME:		8. DOB:	9. SEX:
10. HOME ADDRESS:				11. CITY:		12. STATE:	13. ZIP

### PLAN SELECTION

14. PLAN: Select plan you are enrolling in:
- Delta Dental PPO Plus Premier - Low Plan**
- Delta Dental PPO Plus Premier - High Plan**

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

15. FIRST NAME	16. LAST NAME: (IF DIFFERENT FROM SUBSCRIBER)	17. DATE OF BIRTH	18. SEX M/F	
SUBSCRIBER				
SPOUSE				
CHILDREN				

### 20. REASON FOR SUBMISSION (CHECK ONE)

- |  |   |
|--|---|
| <input type="checkbox"/> New Addition<br><input type="checkbox"/> Individual <input type="checkbox"/> Family | <input type="checkbox"/> Transfer from sublocation _____ to _____   |
| <input type="checkbox"/> Termination   | <input type="checkbox"/> Status change<br><input type="checkbox"/> Individual to family <input type="checkbox"/> Family to individual               |
| <input type="checkbox"/> Add dependent to family   | <input type="checkbox"/> COBRA  |
| <input type="checkbox"/> Reinstatement   | <input type="checkbox"/> Reinstatement of Subscriber<br><input type="checkbox"/> Individual to family <input type="checkbox"/> Family to individual |
| <input type="checkbox"/> Remove dependent _____ (name)   | Transfer to COBRA Sublocation _____   |
| <input type="checkbox"/> Name change   | New addition of dependent formerly covered under ID# _____  |
| <input type="checkbox"/> Address change  |   |
| <input type="checkbox"/> Remove dep. from student status _____ (name)  |   |

### 21. 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 DAY
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26. 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 DAY
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I certify 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 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 contribution for this coverage, I authorize the deduction of this amount from my wages.

24. Subscriber Signature \_\_\_\_\_ Date \_\_\_\_\_ Benefit Administrator Authorization \_\_\_\_\_ Date \_\_\_\_\_