

Delta Dental of Massachusetts
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ENROLLMENT FORM

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

1. GROUP NAME: City of Somerville		2. EFFECTIVE DATE:	3. DATE OF HIRE:	4. GROUP NUMBER 006151	
5. SOCIAL SECURITY NO.	6. LAST NAME (Subscriber)		7. FIRST NAME:		8. DOB:
10. HOME ADDRESS:			11. CITY:	12. STATE:	13. ZIP

PLAN SELECTION

14. PLAN: Select plan you are enrolling in:

- Active Low Plan (6151-9905)
 Retiree Low Plan (6151-9906)
 Active High Plan (6151-9901)
 Retiree High Plan (6151-9903)

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	19. CHECK IF DEPENDENT IS OVER 19 AND FULL TIME STUDENT
SUBSCRIBER				
SPOUSE				
CHILDREN				

20. REASON FOR SUBMISSION (CHECK ONE)

- New Addition
 Individual
 Family
 Transfer from sublocation _____ to _____
 Status change
 Individual to family
 Family to individual
 Termination
 Add dependent to family
 COBRA
Reinstatement of Subscriber
 Individual to family
 Family to individual
 Reinstatement
 Remove dependent _____ (name)
 _____ Transfer to COBRA Sublocation _____
 Name change
 Address change
 Remove dep. from student status _____ (name)
 _____ New addition of dependent formerly covered under ID# _____

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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22. 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.

23. Subscriber Signature _____

Date _____

Benefit Administrator Authorization _____

Date _____