



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: MIT Retiree Dental Plan		2. EFFECTIVE DATE		3. GROUP NUMBER 000444-9901	
4. SOCIAL SECURITY NO.	5. LAST NAME (Subscriber)	6. FIRST NAME:		7. DOB:	8. SEX:
9. HOME ADDRESS:		10. CITY:	11. STATE:	12. ZIP	

PLAN SELECTION

13. PLAN: Select plan you are enrolling in:

Delta Dental PPO *Plus Premier*

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

14. FIRST NAME	15. LAST NAME: (IF DIFFERENT FROM SUBSCRIBER)	16. DATE OF BIRTH	17. SEX M/F	18. CHECK IF DEPENDENT IS OVER 19 AND FULL TIME STUDENT
SUBSCRIBER				
SPOUSE				
CHILDREN				

19. REASON FOR SUBMISSION (CHECK ONE)

- | | |
|---|--|
| <input type="checkbox"/> New Addition | <input type="checkbox"/> Transfer from sublocation _____ to _____ |
| <input type="checkbox"/> Individual | <input type="checkbox"/> Status change |
| <input type="checkbox"/> Individual+1 | <input type="checkbox"/> Individual to family |
| <input type="checkbox"/> Family | <input type="checkbox"/> Individual+1 |
| <input type="checkbox"/> Termination | <input type="checkbox"/> Family to individual |
| <input type="checkbox"/> Add dependent to family | <input type="checkbox"/> COBRA |
| <input type="checkbox"/> Reinstatement | Reinstatement of Subscriber |
| <input type="checkbox"/> Remove dependent _____ (name) | <input type="checkbox"/> Individual to family |
| <input type="checkbox"/> Name change | <input type="checkbox"/> Individual+1 |
| <input type="checkbox"/> Address change | <input type="checkbox"/> Family to individual |
| <input type="checkbox"/> Remove dep. from student status _____ (name) | ____ Transfer to COBRA Sublocation _____ |
| | ____ New addition of dependent formerly covered
under ID# _____ |

20. 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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21. 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.

22. Subscriber Signature _____ Date _____ Benefit Administrator Authorization _____ Date _____