DELTA DENTAL

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: Tufts University Voluntary Student Dental Plan	2. EFFECTIVE DATE (Internal Use Only)	3. GROUP NUMBER 9340

4. SOCIAL SECURITY NO.	5. LAST NAME (Subscriber)	6. FIRST NAME:	7. DOB:	8. SEX:

9. ADDRESS:	10: CITY:	11. STATE:	12. ZIP

PLAN SELECTION

13a. PLAN:

- ☐ Delta Dental Premier
- ☑ Delta Dental PPO ***Plus Premier***
- ☐ Delta Dental PPO
- ☐ Delta Dental PPO Value
- ☐ DeltaCare

13b. Check applicable box for your affiliation:

- ☐ ASE (9906)
- ☐ Grad ASE (9909)
- ☐ Nutrition (9912)
- ☐ **Dental (9907)**
- ☐ **Medicine - MD (9910)**
- ☐ **Biomedical Sciences (9913)**
- ☐ Fletchr (9908)
- ☐ Medicine - PHPD (9911)
- ☐ Vet (9914)

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)

- ☐ New Addition
  - ☐ Individual ☐ Family
- ☐ Termination
- ☐ Add dependent to family
- ☐ Reinstatement
- ☐ Remove dependent _________________(name)
- ☐ Name change
- ☐ Address change
- ☐ Remove dep. from student status ____________ (name)
- ☐ Transfer from sublocation ____________to _________
- ☐ Status change
  - ☐ Individual to family ☐ Individual+1 ☐ Family to individual
- ☐ COBRA
  - Reinstatement of Subscriber
  - ☐ Individual to family ☐ Individual+1 ☐ Family to individual
  - ____ 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

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

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 ____________

Please return your completed form to EBPA, 37 Industrial Drive Suite E, Exeter NH 03833