DELTA DENTAL®

Cambridge Public Employees Dental & Vision Fund

Delta Dental PPO℠ Plus Premier Enrollment/Change Form

PLEASE PRINT OR TYPE – BE SURE FORM IS COMPLETED IN FULL TO ENSURE ENROLLMENT/CHANGES

GROUP INFORMATION: TO BE COMPLETED BY EMPLOYER

1. GROUP NAME*:	2. EFFECTIVE DATE*:	3. GROUP NUMBER*:

SUBSCRIBER INFORMATION: TO BE COMPLETED BY EMPLOYEE

***REQUIRED FIELDS FOR ENROLLMENT**

4. LASTNAME *	5. FIRST NAME *		
6. SOCIAL SECURITY *	7. DATE OF BIRTH *		8. GENDER *
9. HOME ADDRESS *	10. CITY *	11. STATE *	12. ZIP CODE *
13. PRIMARY PHONE *	14. SECONDARY PHONE	15. EMAIL ADDRESS	

DEPENDENT INFORMATION: List all dependent(s) covered, to be newly enrolled, removed, or affected by any changes.

Dependent children between age 19-26 must complete age 19-26 dependent form and be claimed on members taxes. Dependents age 19-25 that are full-time students, must submit student verification status. Permanently disabled dependents must complete disabled dependent application.

16. FIRST NAME*	17. LAST NAME*	18. DATE OF BIRTH*	19. GENDER*	20. SELECT*
SPOUSE				ADD ☐ REMOVE ☐
CHILDREN				ADD ☐ REMOVE ☐
				ADD ☐ REMOVE ☐
				ADD ☐ REMOVE ☐
				ADD ☐ REMOVE ☐
				ADD ☐ REMOVE ☐

21. COORDINATION OF BENEFITS

ARE ☐ YOU OR ☐ ANY OTHER FAMILY MEMBER COVERD BY ANOTHER DENTAL PLAN? ☐ NO ☐ YES

IF YES, PLEASE INDICATE NAME OF COVERED INDIVIDUAL_____ Subscriber ID#:_____

OTHER DENTAL INSURANCE COMPANY:	EMPLOYER NAME:	POLICY HOLDER ID NO:	EFFECTIVE DATE:

REASON FOR SUBMISSION

☐ New Enrollment ☐ Reinstatement

☐ Individual ☐ Individual +1 ☐ Family

☐ Termination

☐ Adding Dependent(s):

☐ Spouse ☐ Dependent Children

☐ Removing Dependent(s):

☐ Spouse/Ex-Spouse ☐ Dependent Children

☐ Information Change:

☐ Address Change ☐ Gender Change ☐ Name Change

Previous Name:_____

☐ Other (Explain):_____

☐ Transfer from sublocation _____ to _____

☐ COBRA

☐ Reinstatement of Subscriber ☐ Transfer to COBRA

I certify that all information is true and correct to the best of my knowledge. I agree to allow Delta Dental to communicate information to me related to my plan using the information provided. 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 contributions for this coverage, I authorize the deduction of the is amount from my wages. **By signing below I herby accept coverage**.

SUBSCRIBER SIGNATURE:_____ DATE: _____

Dental & Vision Administrator(s) Use Only:

BENEFIT ADMINISTRATOR AUTHORIZATION:_____ DATE: _____