

ENROLLMENT FORM

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

Delta Dental of Massachusetts **Customer Service** (617) 886-1234 Toll Free (800) 872-0500 MA & Nat's Toll Free (800) 451-1249 PO Box 9695 Corporate Office (617) 886-1000 Boston, Massachusetts 02114 Fax (617) 886-1293 www.deltadentalma.com

1. GROUP NAME: 2. EFFECTIVE DATE: TOWN OF WESTWOOD					3. D/	ATE OF HIRE:		4. GROUP NUMBER: 010015		
5. LAST NAME: (Subscriber)					6. FIR		•			
7. SOCIAL SECURITY NO.:	1	8. DAT	E OF BIRT							
10. HOME	11. CITY:			Y:		: 13.7	13. ZIP:			
ADDRESS:	FIRST CONTRACTOR	PLAI	N SE	LECTIC	N					
14. PLAN: Select plan you	are enrolling in:					2.65% 医延伸性				
DELTA DEN	TAL BASIC		ELT	A DEN	ITAL E	ENHANCED	•		į.	
PLEASE LIST ALL	ELIGIBLE DEPENDE	NT(S) COV	ERE	D UND	R YO	UR POLICY				
	16. LAST NAME (IF DIFFERENT FROM SUBSCRIBER)	17. DATE OF BIRTH	SEX M/F	19. CHECK IF DEPENDENT IS OVER 19 AND A FULL TIME STUDENT		DELTACARE OR VALUE PLAN ONLY				
15. FIRST NAME						OOSE A PCD FOR I		1. PROVIDEI	₹#	22. DO YOU CURRENTLY USE THIS DENTIST
SUBSCRIBER						THE RESIDENCE SECTION AND AN ADVANCED BY		22136 336 456 456 456		DENINI
SPOUSE		2								1
CHILDREN										
23.	REASC	N FOR SU	IBM	SSION	(CHEC	CK ONE)				
New Addition Individual In Termination Add dependent to fan Reinstatement Remove dependent Name change Address change Remove dep. from str	☐ Transfer from sublocation							nily to Indiv	ridual	
24. COORDINATION OF BE Are □ you OR □	ENEFITS any other family member cove	rad by another	dont	al pian?	□No		ease indic	ate name o	f covered in	idividual:
OTHER DENTAL INSURANCE CO.:	EMPLOYER NAME:	uenta	ai piaii:		POLICY HOLDER ID NO.:			EFFECTIVE DATE		
25. Are □ you OR □	any other family member cove	red by another	medi	cal plan?	□ No	If YES, p ☐ Yes	lease indi	cate name o	of covered in	ndividual:
OTHER MEDICAL INSURANCE CO.:	EMPLOYER NAME:		•		POLICY HOLDER ID NO.:			EFFECTIVE DATE		
ship will be determined by	n is true and correct to the best my employer or plan sponsor ployee contributions for this cov	in accordance	with t	he underw	ritina aui	idelines of Delta D	ental of N	rmination d Nassachuse	ate of my n tts. In addit	nember- ion, if

Benefit Administrator Signature

Date

Date

DDD 605 (05/10)

26. Subscriber Signature