DELTA DENTAL

OPEIU Local 6 and Trial Court of MA Health and Welfare Fund

Enrollment/Change Form

COMPLETE AND RETURN TO YOUR PAYROLL COORDINATOR

DELTA DENTAL PPO *PLUS PREMIER*

Date of Hire: _____

Effective Date of Insurance:

Group Number: 000674

Select Plan: _____(Option 1)

_____(Option 2 with Ortho)

1. Last Name (Employee):	2. First Name	3. Social Security No.	4. Date of Birth	5. Gender & Marital Status	
				☐ Female ☐ Male	☐ Single ☐ Married ☐ Divorced

6. Home Address	7. City	8. State	9. Zip

Telephone Number:

Home:_____ Cell: _____

Email Address (optional): _____

Work Location: _____

PLEASE LIST ALL ELIGIBLE DEPENDENTS COVERED UNDER YOUR DENTAL POLICY

10. First Name	11. Last Name (If Different From Subscriber)	12. Date of Birth	13. Sex (M/F)	14. Check if Dependent is Over 19 and a Full Time Student (✓)
Spouse				
Children				

15. Reason for Submission:

☐ New Addition-Coverage Type:
_____ Individual
_____ Family

☐ Termination on: ___/___/___

☐ Annual Open Enrollment

☐ Change of Name/Address

☐ Change of Status
Exact date of Event: __/__/____

Change in Status Due to:

☐ Marriage – Formerly: _____

☐ Birth

☐ Adoption

☐ Spouse's Employment Change

☐ Termination of Dependent

☐ Divorced

☐ Deceased

16. Coordination of Benefits:

Are ☐ You or ☐ Any other family member covered by another dental plan? ☐ Yes ☐ No

If yes, please indicate name of covered individuals:_____

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 THE EMPLOYER OR PLAN SPONSOR. IF THE EMPLOYER OR PLAN SPONSOR REQUIRED EMPLOYEE CONTRIBUTIONS FOR THIS COVERAGE I AUTHORIZE THE DEDUCTIONS OF THESE AMOUNTS FROM MY WAGES ON A PRETAX BASIS. I UNDERSTAND THAT DEPENDENTS MUST REMAIN ENROLLED AND BE DROPPED ONLY DURING CONTRACT REOPENING, EXCEPT IN THE EVENT OF FAMILY STATUS CHANGE.

Benefit Adminstrator Signature:_____ Date_____ Employee Signature:_____

Retain a Copy For Your Records.