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: _____