

BOSTON COLLEGE

DELTA DENTAL ENROLLMENT FORM

Delta Dental Plan of Massachusetts, www.deltamass.com

Tel: (617) 886-1234, (800) 872-0550

GROUP NAME: BOSTON COLLEGE	EFFECTIVE DATE (MM/DD/YY)	DATE OF HIRE (MM/DD/YY)	GROUP NUMBER 4542	
SUBSCRIBER : SOCIAL SECURITY NO.	LAST NAME	FIRST NAME	DOB	SEX
HOME ADDRESS.	CITY	STATE	ZIP	

PLAN: Select a plan you are enrolling in: DeltaPremier DeltaCare
 If DeltaCare is selected, the subscriber & each dependent must choose a DeltaCare Primary Care Dentist (PCD) from the DeltaCare network of participating dentists.

PLEASE LIST ALL ELIGIBLE DEPENDENT(S) COVERED UNDER YOUR POLICY

					DELTACARE ONLY		
FIRST NAME	LAST NAME	DOB	SEX	CHECK IF CHILD IS OVER 19 AND A FULL TIME STUDENT	CHOOSE A PCD FOR EACH COVERED INDIVIDUAL	PROVIDER #	DO YOU CURRENTLY USE THIS DENTIST?
SUBSCRIBER							
SPOUSE							
CHILDREN							

REASON FOR SUBMISSION (CHECK ONE)

- New Addition
 - Individual Family
- Termination
- Add dependent to family
- Remove dependent listed above
- Name Change
- Address Change
- Status change
 - Individual to Family Family to Individual

I certify that all information is correct . I understand that the effective date and termination date of my membership will be determined by my employer in accordance with the underwriting guidelines of Delta Dental Plan of Massachusetts. In addition, I authorize the deduction of any required contribution from my wages.

Subscriber Signature	Date	Benefit Administrator Authorization	Date
----------------------	------	-------------------------------------	------

After completion, please print, sign, and submit to the Benefits Office, More Hall 325

