DELTA DENTAL

ENROLLMENT FORM

Please print or type be sure the form is completed in full to ensure enrollment

C/O Northeast Business Trust
P.O. Box 5059
Billerica, Ma. 01822-5059
Tel 800-464-0039
Fax 978-663-5431
e-mail sales@nbtgroup.com

1. GROUP NAME: NORTHEAST BUSINESS TRUST	2. EFFECTIVE DATE:	3. DATE OF HIRE:	4. GROUP NUMBER: 9998-9004

5. SOCIAL SECURITY NUMBER:	6. LAST NAME (SUBSCRIBER):	7. FIRST NAME:	8. DATE OF BIRTH:	9. SEX:

10. HOME ADDRESS:	11. CITY :	12. STATE:	13. ZIP CODE:

PLAN SECTION

14. PPO Value plan

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

15. FIRST NAME	16. LAST NAME (IF DIFFERENT FROM SUBSCRIBER)	17. DATE OF BIRTH	18. SEX M/F	19. CHECK IF DEPENDENT IS OVER 19 AND A FULL-TIME STUDENT
SUBSCRIBER				
SPOUSE/DOMESTIC PARTNER				
CHIDREN				

REASON FOR SUBMISSION (CHECK ONE)

- ☐ New Addition
  - ☐ Individual ☐ Family
- ☐ Termination
- ☐ Add Dependent to family
- ☐ Reinstatement
- ☐ Remove dependent: _____ name
- ☐ Name change
- ☐ Address change
- ☐ Remove dep. From student status _____ name
- ☐ Transfer from sublocation _____ to _____
- ☐ Status change
  - ☐ Individual ☐ Family
- ☐ COBRA
- ☐ Reinstatement of Subscriber
  - ☐ Individual ☐ Family
- ☐ Transfer to COBRA sublocation: _____
- ☐ New addition of dependent formerly covered under ID # _____

24. COORDINATION OF BENEIFTS

Are ☐ you OR ☐ any other family member covered by another dental plan? ☐ No ☐ Yes

If yes, please indicate name of covered individual _____

Other Dental Insurance Company:	Employer Name:	Policy Holder ID #:	Effective date :

25. Are ☐ you OR ☐ any other family member covered by another medical plan? ☐ No ☐ Yes

If yes, please indicate name of covered individual _____

Other Medical Insurance Company:	Employer Name:	Policy Holder ID #:	Effective date :

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 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 this amount from my wages.

_____ _____ _____ _____

Subscriber Signature Date Benefit Administrator Authorization Date

Submit form to Northeast Business Trust