



Delta Dental Plan of Massachusetts

C/O Northeast Business Trust
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ENROLLMENT FORM

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

1. GROUP NAME: NORTHEAST BUSINESS TRUST
2. EFFECTIVE DATE:
3. DATE OF HIRE:
4. GROUP NUMBER: 6624-
5. SOCIAL SECURITY NO.
6. LAST NAME (Subscriber):
7. FIRST NAME:
8. DOB:
9. SEX:
10. HOME ADDRESS
11. CITY:
12. STATE:13. ZIP:
14. COMPANY NAME:
15. WORK #:
16. HOME #:

PLAN SELECTION

17. PLAN: Select plan you are enrolling in:
[ ] DeltaPremier [ ] DeltaCare
If DeltaCare is selected, each subscriber & dependent must choose a DeltaCare Primary Care Dentist (PCD.)

PLEASE LIST ALL DEPENDENT(S) COVERED UNDER YOUR POLICY

Table with columns: 18. FIRST NAME, 19. LAST NAME, 20. DATE OF BIRTH, 21. SEX M/F, 22. CHECK IF DEPENDENT IS OVER 19 AND A FULL TIME STUDENT, 23. CHOOSE A PCD FOR EACH COVERED INDIVIDUAL, 24. PROVIDER #, 25. DO YOU CURRENTLY USE THIS DENTIST? Includes rows for SUBSCRIBER, SPOUSE, CHILDREN.

26. REASON FOR SUBMISSION (CHECK ONE)

- [ ] New Addition
[ ] Individual [ ] Individual + 1 [ ] Family
[ ] Status change (must be 1st of month)
[ ] Individual to Family [ ] Individual + 1 [ ] Family to Individual
[ ] Termination: Date of termination
[ ] Cobra - Reinstatement of subscriber
[ ] Add dependent to family
[ ] Cobra - new addition of dependent formerly covered under ID #
[ ] Reinstatement
[ ] Name / address change
[ ] Number of months Cobra eligible
[ ] Remove dependent from student status
[ ] Cobra - reinstatement - transfer to Cobra sublocation
[ ] Transfer from sublocation to

27. COORDINATION OF BENEFITS

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 NO.: EFFECTIVE DATE

28. 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 NO.: 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 Plan of Massachusetts. In addition, if my employer requires employee contributions for this coverage, I authorize the deduction of this amount from my wages.

29. Subscriber Signature

Date

Benefit Administrator Authorization

Date