Print Form

Delta Dental of Massachusetts
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Disabled Dependent Application

1. SUBSCRIBER NAME
FIRST LAST

2. SUBSCRIBER ID NUMBER	3. GROUP ID NUMBER	4. GROUP NAME

5. ADDRESS (Number, Street, City, State and Zip Code)

6. NAME OF DEPENDENT CHILD	7. CHILD'S DATE OF BIRTH Month / Date / Year	8. DATE CHILD'S DISABILITY OCCURRED

9. IS CHILD PERMANENTLY RESIDING IN YOUR HOUSEHOLD ☐ Yes ☐ No IF "NO," EXPLAIN:

10. IS CHILD DEPENDENT UPON YOU FOR SUPPORT?	11. IF "YES," WHAT PART OF SUPPORT DO YOU CONTRIBUTE?	12. IS CHILD LISTED AS A DEPENDENT IN YOUR LAST FEDERAL INCOME TAX STATEMENT?
☐ YES ☐ NO		☐ YES ☐ NO

13. NAME AND ADDRESS OF PHYSICIAN WHO ATTENDED DEPENDENT CHILD.

I have read the foregoing statements and answers and declare them to be true and complete to the best of my knowledge and belief. To the extent permitted by statute, I here by authorize any physician or other person who has attended my above name dependent child o rwho may hereafter attend or examine such child to disclose any knowledge or information thereby acquired by him. Aphotostat of this authorization shall be valid as the original.

SIGNATURE OF SUBSCRIBER DATE

Return Form Directly To: Delta Dental of Massachusetts
P.O. Box 9695, Boston, MA 02114

TO BE COMPLETED BY ATTENDING PHYSICIAN

1. IS CHILD NOW INCAPABLE OF SELF-SUPPORT BECAUSE OF A DISABILITY?	2. HAS SUCH DISABILITY EXISTED CONTINUOSLY SINCE BEFORE CHILD ATTAINED AGE 19?	3.PROGNOSIS (Estimate months or years)
☐ YES ☐ NO	☐ YES ☐ NO	

4. NATURE OF DISABILITY (Please give as much detail as practicable)

SIGNATURE OF PHYSICIAN DATE