I_____________________________________, request that Delta Dental of Massachusetts communicate with me at the alternate address listed below. I ***am the (check one):*** *_____ Subscriber _____ Member (named on Subscriber's policy) ____ Other (please specify)*

If an alternate address is needed for a dependent under the age of 18, please submit legal documentation. Dependents over 18 are required to sign their own forms.

Checks issued for visits to non-participating dentists will continue to be mailed to the Subscriber's address. For a list of participating providers, please check our website www.deltadentalma.com, *or call Customer Service at 800-872-0500.*

Printed Name____

Subscriber ID____

Subscriber Name____

Covered individuals for whom the alternate address should be used:

____

____

____

Alternate contact address:

____

____

____

Preferred Phone number: _________________________________

Please mail document to:
Attn: Enrollment
P.O. Box 2907
Milwaukee, WI 53201-2907

Please sign and date:
I have read the above statement and attest that I require communication about my PHI by the alternate address indicated above.

____ ____

Signature Date

Internal Use only:

Accepted ☐

Denied ☐

Form incomplete ☐

Name:____

Department:____

Date:____