Customer Service: 800-872-0500
Fax: 617-886-1293
Email: enrollment@deltadentalma.com

Delta Dental of Massachusetts
Member Enrollment
P.O. Box 2907
Milwaukee, WI 53201-2907

Disabled Dependent Application

1. SUBSCRIBER NAME FIRST		LAST
2. SUBSCRIBER ID NUMBER	3. GROUP 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? ☐ Yes ☐ No	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
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 hereby authorize any physician or other person who has attended my above named dependent child or who may hereafter attend or examine such child to disclose any knowledge or information thereby acquired by him. A photostat of this authorization shall be valid as the original.

SIGNATURE OF PHYSICIAN _____ DATE _____

Mail form to: Delta Dental of Massachusetts
Member Enrollment
P.O. Box 2907
Milwaukee, WI 53201-2907

Or email to: enrollment@greatdentalplans.com

TO BE COMPLETED BY ATTENDING PHYSICIAN

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

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

SIGNATURE OF PHYSICIAN _____ DATE _____