DELTA DENTAL®

Application and Change Form for Delta Dental Individual and Family™

P.O. Box 9695
Boston, Massachusetts 02114-9695

Customer Service: (800) 872-0500
www.deltadentalma.com/dental_plans/individual.asp

Please print or type. Required fields are starred (*) and must be completed to ensure enrollment. Subscriber must be age 18 or older:

1. *LAST NAME: (Subscriber)	2. MIDDLE INITIAL: (Optional)	3. *FIRST NAME:		
4. *SOCIAL SECURITY NO:	5. *DATE OF BIRTH:	6. *GENDER:		
7. *HOME ADDRESS:	8. *CITY:	9. *STATE:	10. *ZIP:	
11. BILLING ADDRESS: (If different)	12. CITY:	13. STATE:	14. ZIP:	
15. *COUNTY:	16. *PHONE NUMBER:	17. *E-MAIL:		
18. BROKER	19. BROKER EMAIL/PHONE	20. BROKER NPN		

ELIGIBLE DEPENDENT(S) TO BE COVERED UNDER THIS POLICY

If you are applying for **Subscriber Only** coverage, do not complete this section

21. FIRST NAME*	22. MIDDLE INITIAL (optional)	23. LAST NAME* (if different from subscriber)	24. DATE OF BIRTH*	25. SOCIAL SECURITY NUMBER	26. GENDER* M/F	DELTACARE® PLAN ONLY		
						27. CHOOSE A PCD FOR EACH COVERED INDIVIDUAL	28. PROVIDER #	29. DO YOU CURRENTLY USE THIS DENTIST?
Spouse								
Children								

30. Are you a former Delta Dental of Massachusetts member through an Employer plan or COBRA? ☐ No ☐ Yes

If yes, please provide former subscriber ID Number _____ Last Date of Coverage _____

REASON FOR SUBMISSION

31. *CHECK ONE:

☐ New Application ☐ Reinstatement ☐ Termination ☐ Change

IF TERMINATION OR CHANGE, PLEASE COMPLETE BELOW (CHECK ALL THAT APPLY):

☐ Name _____ Phone Number _____

☐ Address _____ Email _____

☐ Coverage to: ☐ Subscriber Only ☐ Subscriber+One ☐ Family

☐ Add Dependent(s) Name _____ Name _____

☐ Remove Dependent(s) Name _____ Name _____

Please use a separate page for additional dependents to be added or removed from plan.

☐ If changing plans indicate new selection: ☐ Delta Dental Individual and Family Premier Option 1 ☐ Delta Dental Individual and Family Premier Option 2

☐ Delta Dental Individual and Family PPO *Value for Seniors* ☐ Delta Dental Individual and Family EPO ☐ DeltaCare

Termination (Reason):

☐ Relocated out of Massachusetts ☐ Have other Dental Plan ☐ Other _____ ☐ Non-Payment ☐ Deceased

DELTA DENTAL PLANS SELECTION

Please refer to the Summary Plan description to review your options

32. *SELECT ONE: ☐ Delta Dental Individual and Family Premier Option 1 ☐ Delta Dental Individual and Family Premier Option 2 ☐ Delta Dental Individual and Family PPO *Value for Seniors*

☐ Delta Dental Individual and Family EPO ($50 Deductible, $1000 Annual Maximum, 100%/70%/40% Coinsurance) ☐ DeltaCare

If DeltaCare is selected, each subscriber & dependent must choose a DeltaCare Primary Care Dentist (PCD).

33. *SELECT ONE: ☐ Age 50 and older ☐ Under age 50

Delta Dental of Massachusetts PPO and Premier insurance products are offered by Dental Service of Massachusetts, Inc.
Delta Dental of Massachusetts EPO and DeltaCare insurance products are offered by DSM Massachusetts Insurance Company, Inc.

To complete this application, you must review the information on page 2, sign in section 34 and mail or fax items to Delta Dental of Massachusetts, P.O. Box 9695, Boston, MA, 02114 | Enrollment Fax: (617) 886-1293

PAYMENT INSTRUCTIONS

Once your enrollment is processed, your first invoice should be received within 5-7 business days. If you would prefer to receive future invoices electronically, you have the option to sign up for email notifications through our member portal.

For new coverage, your first invoice must be paid in full prior to the coverage period, for your policy to be in effect. For all future invoicing, your payments must be received in full no later than the 1st of the month. In the event the payment is returned for insufficient funds, a $25 service fee will be charged to your account and will be reflected on your next invoice.

To submit payment via check, please refer to the invoice detail and include the remit slip, which is the bottom portion of your invoice. Checks and remit slips should be mailed to the PO Box address listed on the invoice.

If you would like to submit payment electronically, please visit the website listed on the invoice to access our member portal. You will have the option to submit a one-time payment from your bank account via automated clearing house (ACH) or credit card, or you can sign up for automatic payments going forward.

COVERAGE PERIOD

The initial term of your policy will be for one year from the Effective Date. After the initial term, this policy will renew automatically establishing a new Effective Date each year until a Change Form is submitted or until this Agreement is terminated. This policy may be terminated upon thirty (30) days written notice to Delta Dental of Massachusetts. Additionally, you must wait at least one year after your cancellation before you can enroll again as a subscriber.

Delta Dental reserves the right to change premium rates upon renewal of the policy. Delta Dental agrees to keep your coverage in force as long as you continue to pay the premiums on time and as long as you retain residency in the state of Massachusetts.

Applications postmarked by the 10th of the month will become effective the 1st of the following month. Examples: Applications postmarked June 10 will have an Effective Date of July 1. Applications postmarked June 11 will have an Effective Date of August 1.

TERMS

By signing below, you verify that you have read and agree to the following:

- Waiting Period: the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the policy.
- **I UNDERSTAND THAT THERE IS A SIX MONTH WAITING PERIOD ON BASIC RESTORATIVE SERVICES AND A TWELVE MONTH WAITING PERIOD ON MAJOR RESTORATIVE SERVICES. (DeltaCare and Delta Dental Individual and Family PPO Value for Seniors plans excluded.)**
  (May be waived for previous Delta Dental of Massachusetts group members who have no more than a 60 day break in coverage.)
- **Pre-existing conditions - Dental expenses incurred in connection with any dental procedure started prior to coverage are excluded. No benefits are available for the replacement of teeth missing prior to the member's effective date of coverage.**
- I confirm that all information is true and correct to the best of my knowledge.

NOTICE: Any person who purposely attempts to commit fraud or deceive an insurer by filing a false claim or an application with false, incomplete or missing information is guilty of a third degree felony and will result in this policy being terminated.

34. *Subscriber Signature _____ Date _____

35. Will this policy replace an active dental insurance policy? ☐ No ☐ Yes (If Yes, please complete the Notice of Information Practices form and include it with this application).

2022 MONTHLY PREMIUM RATE

Delta Dental Individual and Family Premier Option 1	**Age 50 and older**	**Under age 50**
Individual	$61.75	$58.38
Individual +1	$124.62	$110.03
Family*	$192.00	$187.50
Delta Dental Individual and Family Premier Option 2	**Age 50 and older**	**Under age 50**
Individual	$49.60	$46.90
Individual +1	$100.13	$88.41
Family*	$154.26	$150.63
Delta Dental Individual and Family PPO Value for Seniors	**Age 65 and older**	
Individual	$21.43	
Individual +1	$42.85	
Family*	$53.57	
Delta Dental Individual and Family EPO	**Age 50 and older**	**Under age 50**
Individual	$33.03	$30.02
Individual +1	$66.07	$56.59
Family*	$102.79	$96.43
DeltaCare	**Age 18 and older**	
Individual	$26.14	
Individual +1	$51.74	
Family*	$92.52	

Please refer to the Coverage Period section above for information on your effective date and plan renewal terms.
*With family coverage, your eligible dependents are covered to age 26.

DELTA DENTAL

Notice of Information Practices

NOTICE TO APPLICANT REGARDING REPLACEMENT OF DENTAL INSURANCE

Replacement Form

If you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Delta Dental you must sign and return this form with your application. For your own information and protection, certain facts should be pointed out to you which could affect your rights to coverage under the new policy.

1. Health conditions which you may presently have may not be covered under the new policy. This could result in a claim for benefits being denied which have been payable under your present policy.

2. Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.

3. Questions in the application for the new policy must be answered truthfully and completely; otherwise, the validity of the policy and the payment of any benefits thereunder may be voided.

4. It may be to your advantage to secure the advice of your present carrier or its agent regarding the proposed replacement of your present policy. This is your right, under the policy you have chosen.

The above “Notice to Applicant” was delivered to me on:

_____
Date

_____
Signature of applicant

_____
Printed name of applicant