DELTA DENTAL

Massachusetts Federal Employees Dental Plan ENROLLMENT FORM

Delta Dental of Massachusetts

P.O. Box 9695 PLEASE PRINT OR TYPE Boston, Massachusetts, 02114-9695

BE SURE FORM IS COMPLETED IN FULL TO ENSURE ENROLLMENT

Customer Service: (617) 886-1234 Toll Free (800) 872-0500 Corporate Office: (617) 886-1000 MA & NAT'L Toll Free (800) 451-1249 Sponsored by Hanscom Federal Credit Union Fax: (617) 886-1293 www.deltadentalma.com

1. GROUP NAME: Federal Employee Dental Program	2. EFFECTIVE DATE:	4. GROUP NUMBER 9506-6307		
4. SOCIAL SECURITY NO.	5. LAST NAME (Subscriber)	6. FIRST NAME:	7. DOB:	8. SEX:
9. HOME ADDRESS:	10: CITY:	11. STATE:	12. ZIP	
13. PHONE NUMBER	14. E-MAIL ADDRESS	15. AGENCY		

PLEASE LIST ALL ELIGIBLE DEPENDENT(S) COVERED UNDER YOUR POLICY

16. FIRST NAME	17. LAST NAME: (IF DIFFERENT FROM SUBSCRIBER)	18. DATE OF BIRTH	19. SEX M/F
SUBSCRIBER			
SPOUSE			
CHILDREN			

20. PREMIER VOLUNTARY ENHANCED TABLE PLAN - REASON FOR SUBMISSION (CHECK ONE)

- ☐ New Addition
  - ☐ Individual ☐ Family
- ☐ Termination
- ☐ Add dependent to family
- ☐ Reinstatement
- ☐ Remove dependent _____ (name)
- ☐ Retirees
- ☐ Name change
- ☐ Address change
- ☐ Status change
  - ☐ Individual to Family ☐ Family to Individual

21. METHOD OF PAYMENT (You must have a Hanscom Federal Credit Union checking account to enroll)

Please fill out your account information and include a copy of your Government ID and a voided check with your enrollment form to the address listed above.

Rates are valid from **07/1/20-06/30/22** Monthly Premium: Individual: $39.00 Family: $97.00

Your Hanscom Federal Credit Union checking account will be debited monthly: Please fill in your account information and include avoided check with your enrollment form:

Name on Checking Account:_____ Routing Number: 211380483

Hanscom FCU member number:

22. 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 MEDICAL INSURANCE COMPANY:	EMPLOYER NAME:	POLICY HOLDER ID NO.:	EFFECTIVE DAY

23. Are ☐ you OR ☐ any other family member covered by another dental plan? ☐ No ☐ Yes

If YES, please indicate name of covered individual _____ .

OTHER MEDICAL INSURANCE COMPANY:	EMPLOYER NAME:	POLICY HOLDER ID NO.:	EFFECTIVE DAY

I certify that all information is true and correct to the best of my knowledge. I understand my enrollment from needs to be received by Delta Dental by the 15th of the month in order to be effective the 1st. of the following month. I agree to make premium funds available on the 20th of each month and authorize Delta Dental of Massachusetts to withdraw funds from my credit union account listed above. I understand that if the funds are not available or payment is not otherwise timely made, I will no longer be eligible for coverage. I understand the above rates are valid for the period of 7/1/20-6/30/22 and are subject to change at the end of the contract period, provided Delta Dental gives me a 60-day advance notice. I have read and understand all the above information.

Your signature (Form will not be processed without signature.) Date