



ENROLLMENT FORM

PLEASE PRINT OR TYPE -
BE SURE FORM IS COMPLETED IN FULL TO ENSURE ENROLLMENT

Delta Dental of Massachusetts
PO Box 9695
Boston, Massachusetts 02114

Customer Service (617) 886-1234
Corporate Office (617) 886-1000
Enrollment Fax (617) 886-1293

Toll Free (800) 872-0500
MA & Nat's Toll Free (800) 451-1249
www.deltadentalma.com

1. GROUP NAME:	2. EFFECTIVE DATE:	3. DATE OF HIRE:	4. GROUP NUMBER:
5. LAST NAME: (Subscriber)		6. FIRST NAME:	
7. SOCIAL SECURITY NO.:	8. DATE OF BIRTH:	9. GENDER: F / M	
10. HOME ADDRESS:	11. CITY:	12. STATE:	13. ZIP:

PLAN SELECTION

14. PLAN: Select plan you are enrolling in:

☐ Delta Dental Premier ☐ Delta Dental PPO ☐ Delta Dental PPO Plus Premier ☐ Delta Dental EPO ☐ DeltaCare ☐ The Value Plan

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

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

15. FIRST NAME	16. LAST NAME (IF DIFFERENT FROM SUBSCRIBER)	17. DATE OF BIRTH	18. SEX M/F	19. CHECK IF DEPENDENT IS OVER 19 AND A FULL TIME STUDENT	20. CHOOSE A PCD FOR EACH COVERED INDIVIDUAL	21. PROVIDER #	22. DO YOU CURRENTLY USE THIS DENTIST
SUBSCRIBER							
SPOUSE							
CHILDREN							

23. REASON FOR SUBMISSION (CHECK ONE)

- | | |
|--|--|
| <input type="checkbox"/> New Addition
<input type="checkbox"/> Individual <input type="checkbox"/> Individual+SP <input type="checkbox"/> Individual+CH <input type="checkbox"/> Family
<input type="checkbox"/> Termination
<input type="checkbox"/> Add dependent to family
<input type="checkbox"/> Reinstatement
<input type="checkbox"/> Remove dependent _____ name
<input type="checkbox"/> Name change
<input type="checkbox"/> Address change
<input type="checkbox"/> Remove dep. from student status _____ name | <input type="checkbox"/> Transfer from sublocation _____ to _____
<input type="checkbox"/> Status change
<input type="checkbox"/> Individual to Family <input type="checkbox"/> Individual + 1 <input type="checkbox"/> Family to Individual
COBRA
<input type="checkbox"/> Reinstatement of Subscriber
<input type="checkbox"/> Individual <input type="checkbox"/> Individual + 1 <input type="checkbox"/> Family
<input type="checkbox"/> Transfer to COBRA Sublocation
<input type="checkbox"/> New addition of dependent formerly covered under ID # _____ |
|--|--|

24. COORDINATION OF BENEFITS

If YES, please indicate name of covered individual:

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

OTHER DENTAL INSURANCE CO.:	EMPLOYER NAME:	POLICY HOLDER ID NO.:	EFFECTIVE DATE
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25. If YES, please indicate name of covered individual:

Are ☐ you OR ☐ any other family member covered by another medical plan? ☐ No ☐ Yes _____

OTHER MEDICAL INSURANCE CO.:	EMPLOYER NAME:	POLICY HOLDER ID NO.:	EFFECTIVE DATE
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I certify that all information is true and correct to the best of my knowledge. Also, I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Delta Dental of Massachusetts. In addition, if my employer requires employee contributions for this coverage, I authorize the deduction of this amount from my wages.

26. Subscriber Signature _____

Date _____

Benefit Administrator Signature _____

Date _____

Visit deltadentalma.com for detailed benefit information

**Coverage Summary for
City of Waltham
Group #009132
Effective 7/1/2020**

Deductible: \$50 per individual / \$150 per family. Deductible waived for Diagnostic and Preventive categories.

Calendar Year Maximum: \$1,000 per person.

		Co-Insurance	
Category / Procedure	Qualifications	In Network	Out of Network
Diagnostic Comprehensive Evaluation Periodic Oral Exam Panoramic or Full Mouth X-rays Bitewing X-rays Single Tooth X-rays	Once every 60 months. Twice per calendar year. Once every 60 months. Twice per calendar year. As needed.	100%	100%
Preventive Teeth Cleaning Fluoride Treatments Space Maintainers Sealants	Twice per calendar year. Twice per calendar year for members under age 19. Required due to the premature loss of teeth. For members under age 14 and not for the replacement of primary or permanent anterior teeth. Unrestored permanent molars, every 4 years per tooth for members through age 15. Sealants also covered for members age 16 up to age 19 with a recent cavity and are at risk for decay.	100%	100%
Restorative Silver Fillings White Fillings (Front Teeth) Inlays and White Fillings (Back Teeth) Protective Restorations Stainless Steel Crowns	Once every 24 months per surface per tooth. Once every 24 months per surface per tooth. Covered only for single surfaces. Once every 24 months per surface, per tooth, multi-surfaces will be processed as a silver filling and the patient is responsible for the difference between the silver filling and the Delta Dental negotiated fee for white fillings, where permitted by state law. In other states, the patient may be responsible for paying up to the provider's full submitted charge for white fillings. Once per tooth. Once every 24 months per tooth (on primary teeth only).	80%	80%
Oral Surgery Extractions General Anesthesia	Once per tooth. General Anesthesia and IV sedation allowed with covered surgical impacted teeth only (up to one hour).	80%	80%
Periodontics (on natural teeth only) Periodontal Surgery Scaling and Root Planing Periodontal Cleaning Bone Grafts/GTR	One surgical procedure per quadrant in 36 months. Once in 24 months, per quadrant. No more than 2 quadrants per date of service. Once every 3 months following active periodontal treatment. Not to be combined with preventive cleanings. No more than 2 teeth per quadrant per 36 months on natural teeth.	80% 100% 80%	80% 100% 80%
Endodontics Root Canal Treatment Root Canal Retreatment Vital Pulpotomy	Once per tooth. Once per tooth after 24 months have elapsed from initial treatment Limited to deciduous teeth.	80%	80%
Prosthetic Maintenance Bridge or Denture Repair Crown or Onlay Repair Rebase or Reline of Dentures Recement of Crowns & Onlays, Bridges	Once per bridge/denture per 12 months, after 24 months of initial insertion. Once per tooth per 12 months after 24 months of initial placement Once per denture within 36 months. Once per crown, onlay or bridge.	80%	80%
Emergency Dental Care Palliative Treatment	Three occurrences in 12 months.	80%	80%
Prosthodontics Dentures Fixed Bridges Implants (only in lieu of a 3-unit bridge) Implant Abutments	Once within 60 months (age 16 and older). Once within 60 months (age 16 and older). Endosteal Implant: Only when replacing one missing tooth and when adjacent teeth are healthy and do not require crowns. Once per 60 months per Implant. (Pre-estimate recommended). Once per implant only when surgical implant is benefitted.	50%	50%
Major Restorative Crowns or Onlay Cast Posts/Buildups	When teeth cannot be restored with regular fillings. Once within 60 months per tooth (age 12 and older). Once per tooth per 60 months only benefitted to retain a crown.	50%	50%
Dependent Eligibility: Eligible dependents are covered until the last day of the month of the member's 26 th birthday.			

Additional Benefit Information

Ask your dentist to submit a pre-treatment estimate to Delta Dental for any procedure that exceeds \$300. This will help you estimate any out-of-pocket expenses you may incur and will confirm that this services are covered under your dental coverage.

*Non-participating dentists may balance bill. Subscribers are responsible for the difference between the non-participating maximum plan allowance and the full fee charged by the dentist.

Delta Dental Premier



Easy Access and Great Value – Your Delta Dental Networks

As a Delta Dental Premier subscriber, you have access to the most extensive dental network in Massachusetts, with more than 11,000 participating dentist locations.

With Delta Dental Premier, you enjoy the greatest savings in out-of-pocket expenses when visiting a dentist who participates in the Delta Dental Premier network. Participating dentists typically accept discounted fees for their services, and since your co-payments are based on these fees, you pay lower out-of-pocket costs for your care. You will still receive coverage if you visit a non-participating dentist, but your benefit will be at the out-of-network level shown in the right-hand column of this coverage summary.

Delta Dental members can also take advantage of expanded discounts on many covered services, even after they have used up their benefit dollars, visit limits and other situations. Get the details at <http://www.deltadentalma.com/members/discounts-on-covered-services/>

To find a dentist, simply visit **www.deltadentalma.com** (click on the Find a Dentist link and select Delta Dental Premier) or call Delta Dental customer service at 1-800-872-0500.

Learn more at deltadentalma.com

Visit the member area of **www.deltadentalma.com** to find plan information, review eligibility status, check on claim status, or find a dentist. If you have any questions or need additional information, you can call customer service at 1-800-872-0500.

You can also find more information about your plan in the Delta Dental Member Guide, available from your benefits administrator or online at **www.deltadentalma.com**. In the guide, you can learn how to use your benefits, how to find a dentist or specialist, how to access online resources, and more about keeping a healthy mouth for life.

The information on this coverage summary should be used only as a guideline for your dental benefits plan. For detailed information on your group's plan, riders, terms and conditions, or limitations and exclusions, refer to your plan's Subscriber Certificate, which is available through your benefits administrator.

Your Plan is Administered by:
Delta Dental of Massachusetts
1-800-872-0500
www.deltadentalma.com

465 Medford Street
Boston, MA 02129

NONDISCRIMINATION NOTICE

Delta Dental of Massachusetts complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Delta Dental of Massachusetts does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Delta Dental of Massachusetts:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - o Qualified sign language interpreters
 - o Written information in other formats (large print, audio, and accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
 - o Qualified interpreters
 - o Information written in other languages

If you need these services, visit: <http://www.deltadentalma.com> or call the number on your member ID card.

If you believe that Delta Dental of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Ugonna Onyekwu
Civil Rights Coordinator
Compliance Department
465 Medford Street
Boston, MA 02129
Fax: 617-886-1390
Phone: 617-886-1683
Email: FairTreatment@greatdentalplans.com
TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ugonna Onyekwu is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. You can file a complaint electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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 DSM Massachusetts Insurance Company, Inc.

Delta Dental Premier

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-872-0500 (TTY: 1-844-233-4524).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-872-0500 (TTY: 1-844-233-4524).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-872-0500 (TTY: 1-844-233-4524)。

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-872-0500 (TTY: 1-844-233-4524).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-872-0500 (TTY: 1-844-233-4524).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-872-0500 (TTY: 1-844-233-4524).

مقرب لصحتنا. نأجل اب لفل رفافتت ةيوجلل دعاسمل تامدخ ناف، ةغلل رلفذا ثدحتت نك اذا: تطوحم 1-800-872-0500 (TTY: 1-844-233-4524).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយភាសាដោយមិនគិតឈ្នួលគឺអាចមានសំរាប់អ្នក។ ចូរទូរស័ព្ទ 1-800-872-0500 (TTY: 1-844-233-4524)។

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-872-0500 (TTY: 1-844-233-4524).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-872-0500 (TTY: 1-844-233-4524).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-872-0500 (TTY: 1-844-233-4524). 번으로 전화해 주십시오.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-872-0500 (TTY: 1-844-233-4524).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-872-0500 (TTY: 1-844-233-4524).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-872-0500 (TTY: 1-844-233-4524) पर कॉल करें।

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-872-0500 (TTY: 1-844-233-4524).