

MCOFU HEALTH AND WELFARE PLAN

DENTAL/VISION ENROLLMENT FORM & PAYROLL DEDUCTION AUTHORIZATION

DELTA DENTAL

Delta Dental Plan of Massachusetts

FAX: 603-647-4668

E-MAIL: CHAYMES@BENSTRAT.COM

MCOFU Administrator Mailing Address:

Benefit Strategies, LLC, PO Box 3938, Manchester, NH 03105-3938

Group Name: MCOFU	Effective Date:	Date of Hire:	Telephone #:	Dental Plan (Check one): Delta Dental PPO Plus Premier	Employer: (Check one): <input type="checkbox"/> Comm. Of MA <input type="checkbox"/> Bristol County <input type="checkbox"/> Dukes County <input type="checkbox"/> Plymouth County
Social Security Number:	Last Name (Subscriber):			First Name:	DOB: Sex:
Home Address:				City:	State: Zip Code:

List All LEGAL Dependents Covered Under Your Plan:

Only your **LEGAL** dependents are eligible. Please be prepared to provide proof of legal dependent status if asked, especially if your dependent(s) have a different last name from you.

If any covered dependents are over the age of 19, you must provide documentation that they are Full-Time Students each year.

First Name	Last Name (if different from subscriber)	Date of Birth	Sex (M, F)	Check if dependent is over 19 and a Full Time Student
Subscriber				
Spouse				
Children				

Reason For Submission (Check One)

<input type="checkbox"/> New Enrollment: <input type="checkbox"/> Single Coverage <input type="checkbox"/> Family Coverage <input type="checkbox"/> Coverage Level Change: <input type="checkbox"/> Single to Family <input type="checkbox"/> Family to Single <input type="checkbox"/> Terminate Coverage: Date of Termination: _____	<input type="checkbox"/> Name/Address Change <input type="checkbox"/> Add Dependent(s) to Plan: Name(s) _____ <input type="checkbox"/> Remove Dependent from Student Status: Name _____ <input type="checkbox"/> Add Dependent to Student Status: Name _____ <input type="checkbox"/> Transfer to COBRA Status
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Vision Plan Selected: EyeMed Vision Plan Correctional Industries Voucher Plan
(Check One)

Please Read and Sign Below:

- ❖ I hereby 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 Plan of Massachusetts.
- ❖ I hereby authorize my Employer to deduct from my pay \$3.00/week for Single Coverage or \$6.00/week for Family Coverage as selected above for my participation in the MCO Health and Welfare Fund's Dental/Vision benefit plans. (Dukes County Employee contribution is \$16.17 per week for Single coverage, and \$17.78 per week for Family coverage.)

Employee Signature: _____

Date: _____

Administrator Authorization: _____

Date: _____

Payroll Deduction: \$ _____