

DELTA DENTAL

Delta Dental Plan of Massachusetts

MCOFU Health and Welfare Plan DENTAL/VISION ENROLLMENT FORM & PAYROLL DEDUCTION AUTHORIZATION

FAX: 603-647-4668 – EMAIL: DLEBLANC@BENSTRAT.COM
MAIL TO: MCOFU, PO BOX 1300, MANCHESTER, NH 03105

Your email address: _____

Group Name: MCOFU	Effective Date:	Date of Hire:	Telephone #:	Dental Plan (Check one): Delta Premier PPO DeltaCare	Employer (Check One) Commonwealth of MA Bristol County
Social Security Number:	Last Name (Subscriber):		First Name:	DOB:	Sex:
Home Address:			City:	State:	Zip Code:

List All Dependents Covered Under Your Plan:

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

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	DeltaCare Plan Only This Section MUST be filled out		
					Choose a PCD for each Covered Individual	Provider #	Do you currently use this dentist?
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"/> Change Plan from: <input type="checkbox"/> DeltaPreferred to DeltaCare <input type="checkbox"/> DeltaCare to DeltaPreferred <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
--	--

Vision Plan Selected: <input type="checkbox"/> Cole/EyeMed Vision Plan <input type="checkbox"/> 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.

Employee Signature: _____	Date: _____
Administrator Authorization: _____	Date: _____
	Payroll Deduction: \$ _____