

DELTA DENTAL

Delta Dental Plan of Massachusetts

MCO Health and Welfare Fund DENTAL/VISION ENROLLMENT FORM & PAYROLL DEDUCTION AUTHORIZATION

FAX: 603-647-4668

E-MAIL: DDEMERS@BENSTRAT.COM

MCO H&W Fund Administrator Mailing Address:

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

Group Name: MCO H&W Fund	Effective Date:	Date of Hire:	Telephone #:	Dental Plan <input type="checkbox"/> 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 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
Subscriber				
Spouse				
Children				

Reason For Submission (Check One)

New Enrollment: Single Coverage Family Coverage Coverage Level Change: Single to Family Family to Single Terminate Coverage: Date of Termination: _____	Name/Address Change Add Dependent(s) to Plan: Name(s) _____ Remove Dependent from Student Status: Name _____ Add Dependent to Student Status: Name _____ Transfer to COBRA Status
---	--

Vision Plan Selected:
(Check One)

EyeMed Vision Plan

Correctional Industries Voucher Plan

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: \$ _____