DELTA DENTAL

Delta Dental Plan of Massachusetts

Group ID# 006350

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

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MCO H&W Fund Administrator Mailing Address:

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

Social Security Number:	**Date of Hire:**	**Telephone #:** **Email:**	**Employer (Check One)** __ DOC1000 __ Correctional Industries DOC9005 __ Bristol County BSD1000 __ Plymouth County SDP1000	**Employer (Check One)** __ Dukes County SDD1000 __ Parole Board PAR1000 __ State Police POL4000 __ Trial Court TRC0320

State Employee ID#	**Last Name (Subscriber):**	**First Name:**	**DOB:**	**Gender:**

Home Address:	**City:**	**State:**	**Zip Code:**

List All Dependents Currently Covered Under Your Plan: **Dependent children are covered until to age of 26 (Regardless of Student Status) to the end of the month they turn 26**

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

† **Drop Coverage:**
- ☐ Effective Date: _____

☐ **Name/Address Change :** _____

☐ **Add Dependent(s) to Plan Name & DOB:** _____

Name & DOB: _____ **/ Name & DOB:** _____

☐ **Remove Dependent(s) Name & DOB:** _____

Name & DOB: _____ **/ Name & DOB:** _____

☐ **Transfer to COBRA Status**

Vision Plan Selected: **(Check One)** ☐† **Eye Med 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.
- Commonwealth of MA & Bristol County Employees: I hereby authorize my Employer to deduct from my paycheck $6.00/Bi-Weekly ($3.00 per week) for Single Coverage or $12.00/Bi-Weekly ($6.00 per week) for Family Coverage as selected above for my participation in the MCO Health and Welfare Fund's Dental/Vision benefit plans.
- Dukes County Employees: I hereby authorize my Employer to deduct from my paycheck $35.04/Bi-Weekly ($17.52 per week) for Single Coverage or $38.52/Bi-Weekly ($19.26 per week) for Family Coverage as selected above for my participation in the MCO Health and Welfare Fund's Dental/Vision benefit plans.
- Plymouth County Employees: I hereby authorize my Employer to deduct from my paycheck $0.00/Bi-Weekly for Single or Family Coverage as selected above for my participation in the MCO Health and Welfare Fund's Dental/Vision benefit plans.

Employee Signature: **Date:**

Benefit Strategies Authorization: **Effective Date:** **Payroll Deduction: $**