MA Chamber Dental
ADMINISTERED BY American Benefits Group

CHAMBER DENTAL ENROLLMENT FORM

Upon completion, please return to your HR Department **PLEASE PRINT CLEARLY**

COMPANY NAME: _____

Please Check The Appropriate Plan:

☐ Plan 1: (6730-0001) ☐ Plan 2: (6730-0002) ☐ Plan 3: (6730-0003)

Name: (Last) _____ **(First)** _____

Effective Date: _____ *(to be completed by Employer)* ***Date of Hire:*** _____

Home Address: _____ **Apt #:** _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Sex:** _____ **Social Security #** _____

PLEASE LIST ALL ELIGIBLE DEPENDENTS COVERED UNDER YOUR POLICY					
	First Name	Last name	Date of Birth	Sex M/F	Check here if dependent is over 19 and a full-time student
SPOUSE					
CHILD					
CHILD					
CHILD					
CHILD					
CHILD					

Reason for Submission (Check One)

☐ **New Addition**
- ☐ Individual ☐ Two Person ☐ Family

☐ **Termination (Must be within 30 days)**

☐ **Name change**

☐ **Address change**

☐ **Add dependent to family**

☐ **Remove dependent** _____name

☐ **Status Change**
- ☐ Individual to Family
- ☐ Family to Individual
- ☐ Two Person to Individual
- ☐ Individual to Two Person
- ☐ Family to Two Person
- ☐ Two Person to Family

☐ **COBRA Reinstatement of Subscriber**
- ☐ Individual ☐ Two Person ☐ Family

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.

_____ _____ _____ _____

Employee Signature | Date | Employer Authorization | Date

Please Return To: American Benefits Group, PO BOX 1209 Northampton, MA 01061-1209
or Fax 413-727-7232, Attention: Diane Reynolds

Updated 2/24/2016