Please print, fill out and sign this 'NOTICE TO APPLICANT REGARDING REPLACEMENT OF DENTAL INSURANCE' form (below) and e-mail the completed form to*:
enrollment@deltadentalma.com

**You can also mail the form to us at the following address:**

**Enrollment Department**
Delta Dental of Massachusetts
PO Box 9695
Boston, MA 02114-9695

***Please note that your coverage will NOT be in effect until we receive the completed and signed form.**

## NOTICE TO APPLICANT REGARDING REPLACEMENT OF DENTAL INSURANCE

### Replacement Form

If you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Delta Dental you must sign and return this form with your application. For your own information and protection, certain facts should be pointed out to you which could affect your rights to coverage under the new policy.

1. Health conditions which you may presently have may not be covered under the new policy. This could result in a claim for benefits being denied which have may not be covered under the new policy. This could result in a claim for benefits being denied which have been payable under your present policy.

2. Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.

3. Questions in the application for the new policy must be answered truthfully and completely; otherwise, the validity of the policy and the payment of any benefits thereunder may be voided.

4. It may be to your advantage to secure the advice of your present carrier or its agent regarding the proposed replacement of your present policy. This is your right, under the policy you have chosen.

The above "Notice to Applicant" was delivered to me on:

Signature_______________________________________________Date______________________

_____________________________________________________________________________
Printed name of applicant