Please note that DeltaCare and Altus Dental co-premiums have been reduced by $2.00/week for the 2023 Plan year.

Dental Plan Enrollment Ends December 16, 2022

It is time again to decide if you want to change your dental plan for next year. **If you wish to stay enrolled in your current plan, you do not need to do anything. If you wish to change your plan, you must fill out the form below and return it either electronically to tprendergast@moses-ma.org, or by fax at 617-367-9371, or mail it to the address listed below.**

Each year we get questions asking which plan is best for you and your family. Although that decision is yours to make, we are providing a brief description of each plan starting on page 3. The open plan is more fully described on the reimbursement form. You may visit the Altus website at www.altusdental.com. You may also visit the DeltaCare website at: www.deltamass.com or call DeltaCare at 1-800-327-6277 for more details.

ENROLLMENT ENDS--December 16, 2022

The Mass/MOSES Health and Welfare Trust Fund open enrollment period extends until December 16, 2022. This is your yearly chance to change dental plans. All changes take effect January 1, 2023.

If you wish to stay enrolled in your current plan, you do not need to do anything.

If you wish to change your enrollment, you must fill out the form below and return it *directly to the Trust Fund* (via email, fax, or the address below).

- ☐ I am currently enrolled in the Open (Reimbursement) Plan and would like to switch to the ________ DeltaCare Plan _________ Altus Plan. (choose one) Please send me the necessary enrollment information. I understand that I will be required to pay a weekly co-premium of $2.00 DeltaCare/$2.00 Altus for an individual plan; $6.00 DeltaCare/$11.00 Altus for a family plan; or $6.00 for a 2- person Altus plan.
- ☐ I am currently enrolled in the ______ DeltaCare Plan _________ Altus Plan and would like to switch to the _______DeltaCare Plan __________Altus Plan. I understand that I will be required to pay a weekly co-premium of $2.00 DeltaCare/$2.00 Altus for an individual plan or $6.00 DeltaCare/$11.00 Altus for a family plan or $6.00 for a 2 - person Altus plan.
- ☐ I am currently enrolled in the _______ DeltaCare Plan __________ Altus Plan and would like to switch to the Open (Reimbursement) Plan.

Name: ____ Agency:_____________

Date: ____

Signature: _______________________________ Email ____________________________

Send to: **MASSACHUSETTS/MOSES HEALTH & WELFARE TRUST FUND**
90 N. Washington St, Suite 3
Boston, MA 02114