△ DELTA DENTAL®

Delta Dental of Wisconsin
Enrollment/Change/Waiver Form - Dental
PLEASE NOTE THAT COMPLETING THIS FORM DOES NOT GUARANTEE COVERAGE.

EMPLOYER USE ONLY

GROUP NUMBER _____ EFFECTIVE DATE _____

COMPLETE THIS SECTION IF YOU ARE ACCEPTING, CHANGING, OR TERMINATING COVERAGE

EMPLOYEE LAST NAME	FIRST	M.I.	SSN OR EMPLOYER-ASSIGNED ID	DATE OF BIRTH (M/D/Y)	GENDER F M U
HOME ADDRESS - STREET			CITY	STATE	ZIP
EMPLOYER NAME	EMPLOYER LOCATION	CITY	STATE	DATE OF HIRE (M/D/Y)	

LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED

SPOUSE LAST NAME (IF DIFFERENT)	FIRST	M.I.	GENDER F M U	DATE OF BIRTH (M/D/Y)
CHILD/DEPENDENT LAST NAME (IF DIFFERENT)				

REASON FOR SUBMITTING THIS FORM

NEW ENROLLEE   **REHIRE** (Date: _____)

IF THIS IS FOR CHANGE, WHAT IS THE REASON?   Date Occurred

Birth/Adoption (Name:_____) _____

Marriage/   Divorce _____

Add/   Drop Dependent (Name: _____) _____

Termination of Benefits (Reason: _____) _____

Loss of Dental Benefits _____

Name Change (Former Name: _____) _____

Address Change (_____) _____

Group Transfer (From _____To _____) _____

COBRA Application _____

COVERAGE TYPE

WHAT TYPE OF COVERAGE ARE YOU APPLYING FOR?

Employee Only   Employee & Spouse/
Employee & Child(ren)   Domestic Partner
Entire Family

YOUR MARITAL STATUS   Single   Married

If you are not accepting coverage for your spouse or dependents, are they covered by another dental plan?
Yes   No

ACCEPT COVERAGE
X _____ _____
Signature is Required   Date

COMPLETE THIS SECTION ONLY IF YOU ARE WAIVING COVERAGE

EMPLOYEE LAST NAME	FIRST	M.I.	SSN OR EMPLOYER-ASSIGNED ID	PLEASE CHECK ONE:
EMPLOYER NAME	EMPLOYER LOCATION	CITY	STATE	

PLEASE CHECK ONE:
I have coverage through my spouse
I have other dental coverage
I do not have other dental coverage

WAIVE COVERAGE X _____ _____
Signature is Required   Date

Acceptance of Coverage
I accept the insurance provided by my employer's group insurance plan. I authorize deductions from my earnings for the required contributions toward the cost of insurance. (This authorization applies only if employee contributions are required.) I understand that by accepting insurance, I am required to remain enrolled as a covered employee and cannot make an elective change in the coverage selected until the next open enrollment period, if there is one provided for in the Master Agreement to Provide Dental Benefits.

Waiver of Coverage
I understand that if I decide not to apply for coverage, or if I apply only for single coverage even though I am eligible for family coverage, any subsequent application will be subject to the applicable terms and conditions of the Master Agreement to Provide Dental Benefits, which may require additional limitations and waiting periods. I also understand that Delta Dental of Wisconsin, Inc. reserves the right to reject such an application.

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