



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) / /	SEX F <input type="checkbox"/> M <input type="checkbox"/>
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.	RELATIONSHIP		DATE OF BIRTH (M/D/Y)
			SON	DAU.	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	

REASON FOR SUBMITTING THIS FORM☐ **NEW ENROLLEE** ☐ **REHIRE** (Date: _____)**IF THIS IS FOR CHANGE, WHAT IS THE REASON?**Date
Occurred

- | | |
|---|-------|
| <input type="checkbox"/> Birth/Adoption (Name: _____) | _____ |
| <input type="checkbox"/> Marriage/ <input type="checkbox"/> Divorce | _____ |
| <input type="checkbox"/> Add/ <input type="checkbox"/> Drop Dependent (Name: _____) | _____ |
| <input type="checkbox"/> Termination of Benefits (Reason: _____) | _____ |
| <input type="checkbox"/> Loss of Dental Benefits | _____ |
| <input type="checkbox"/> Name Change (Former Name: _____) | _____ |
| <input type="checkbox"/> Address Change (_____) | _____ |
| <input type="checkbox"/> Group Transfer (From _____ To _____) | _____ |
| <input type="checkbox"/> COBRA Application | _____ |

COVERAGE TYPE**WHAT TYPE OF COVERAGE ARE YOU APPLYING FOR?**

- | | |
|--|--|
| <input type="checkbox"/> Employee Only | <input type="checkbox"/> Employee & Spouse |
| <input type="checkbox"/> Employee & Child(ren) | <input type="checkbox"/> Entire Family |

YOUR MARITAL STATUS☐ Single ☐ MarriedIf 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: <input type="checkbox"/> I have coverage through my spouse <input type="checkbox"/> I have other dental coverage <input type="checkbox"/> I do not have other dental coverage
EMPLOYER NAME	EMPLOYER LOCATION	CITY	STATE	
<input type="checkbox"/> 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.