

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'S LAST NAME	FIRST	M.I.	SSN OR EMPLOYER-ASSIGNED ID	DATE OF BIRTH	MO	DAY	YR	SEX <input type="checkbox"/> F <input type="checkbox"/> M
HOME ADDRESS - STREET	CITY		STATE		ZIP			
EMPLOYER NAME AND LOCATION (CITY & STATE)				DATE OF HIRE	MO	DAY	YR	
LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED				RELATIONSHIP	DATE OF BIRTH			
LAST NAME (IF DIFFERENT)	FIRST	M.I.	SON	DAU.	MO	DAY	YR	
SPOUSE								

REASON FOR SUBMITTING THIS FORM

NEW ENROLLEE REHIRE (Date: _____)

IF THIS IS FOR CHANGE, WHAT IS THE REASON?

- 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

DATE OCCURRED

WHAT TYPE OF COVERAGE ARE YOU APPLYING FOR?

- EMPLOYEE ONLY EMPLOYEE & SPOUSE EMPLOYEE & ONE CHILD
- EMPLOYEE & CHILDREN 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'S LAST NAME	FIRST	M.I.	SSN OR EMPLOYER-ASSIGNED ID	PLEASE CHECK ONE:
EMPLOYER NAME AND LOCATION				<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

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.