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) | SEX F ☐ M ☐ |
|---|---|---|---|---|---|
| | | | | / / | |

| 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 SON | RELATIONSHIP DAU. | DATE OF BIRTH (M/D/Y) |
|---|---|---|---|---|---|
| | | | | | |
| | | | ☐ | ☐ | |
| | | | ☐ | ☐ | |
| | | | ☐ | ☐ | |
| | | | ☐ | ☐ | |
| | | | ☐ | ☐ | |
| | | | ☐ | ☐ | |

### 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) ☐ 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:** |
|---|---|---|---|---|
| | | | | ☐ I have coverage through my spouse<br>☐ I have other dental coverage<br>☐ I do not have other dental coverage |

| EMPLOYER NAME | EMPLOYER LOCATION | CITY | STATE |
|---|---|---|---|
| | | | |

☐ **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.