

ENROLLMENT/CHANGE/WAIVER FORM

PLEASE NOTE THAT COMPLETING THIS FORM DOES NOT GUARANTEE COVERAGE.



Delta Dental Plan of Wisconsin

EMPLOYER USE ONLY

GROUP NUMBER _____ EFFECTIVE DATE _____

SECTION 1: ALL ENROLLEES MUST COMPLETE THIS SECTION

EMPLOYEE'S LAST NAME	FIRST	M.I.	SOCIAL SECURITY NO.	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

NO.	LAST NAME (IF DIFFERENT)	FIRST	M.I.	RELATIONSHIP		DATE OF BIRTH		
				SON	DAU.	MO	DAY	YR
1	EMPLOYEE							
2	SPOUSE							
3								
4								
5								
6								

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 NONE (WAIVE)

YOUR MARITAL STATUS

- SINGLE MARRIED

AT THE TIME THIS PLAN BECOMES EFFECTIVE, WILL YOU BE COVERED BY ANY OTHER DENTAL PLAN?

- YES NO

AT THE TIME THIS PLAN BECOMES EFFECTIVE, WILL YOUR SPOUSE BE COVERED BY ANOTHER DENTAL PLAN?

- YES NO

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. 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.

Accept Coverage

X

SIGNATURE IS REQUIRED

DATE

SECTION 2:

ALL ENROLLEES MUST COMPLETE THIS SECTION

Select one of the three options.
 Note: The option you choose will affect which dentists you may see for services. See brochure for details.

- Delta Dental Premier
- Delta Dental PPO
- DeltaCare

(If selecting the DeltaCare option, Section 3 must also be completed.)

SECTION 3: COMPLETE THIS SECTION ONLY FOR DELTACARE

Persons choosing the DeltaCare plan option must choose a DeltaCare facility for their dental services. A different facility may be chosen for each member. Please list the office location and code number for each person listed. See the blue DeltaCare directory for office locations and code numbers.

NO.	NAME	DELTACARE OFFICE LOCATION	CODE #
1	EMPLOYEE		
2	SPOUSE		
3			
4			
5			
6			