ENROLLMENT/CHANGE/WAIVER FORM

PLEASE NOTE THAT COMPLETING THIS FORM DOES NOT GUARANTEE COVERAGE.

DELTA DENTAL

EMPLOYER USE ONLY

GROUP NUMBER _____ _____ _____ _____ EFFECTIVE DATE _____

SECTION 1: ENROLLEE INFORMATION

EMPLOYEE'S LAST NAME	FIRST	M.I.	SOCIAL SECURITY NO.	DATE OF BIRTH MO DAY YR	SEX
			— —	/ /	☐ F ☐ 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		
NO.	LAST NAME (IF DIFFERENT)	FIRST	M.I.	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?

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 _____

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

☐ Accept Coverage ☐ Waive Coverage

SEE THE BELOW FOR PROVISIONS ON ACCEPTANCE OR WAIVER OF THESE BENEFITS.

X _____ _____

SIGNATURE IS REQUIRED DATE

SECTION 2: PLAN SELECTION

(Complete this section only if you are accepting coverage)

Select one of the options: ☐ High Option ☐ Low Option

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.