

# 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				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: \_\_\_\_\_)    DATE OCCURRED \_\_\_\_\_

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    \_\_\_\_\_

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

X \_\_\_\_\_

SEE THE REVERSE SIDE OF THIS FORM FOR PROVISIONS ON ACCEPTANCE OR WAIVER OF THESE BENEFITS.

SIGNATURE IS REQUIRED

DATE

## SECTION 2: COMPLETE THIS SECTION ONLY IF YOU ARE ENROLLING IN TRISELECT VOLUNTARY

Select one of the three options:

- DeltaPremier
- DeltaPreferred Option
- DeltaCare

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

## SECTION 3: COMPLETE THIS SECTION ONLY FOR DELTACARE

Persons enrolling in a DeltaCare plan 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			

COPY TO EMPLOYER  
ORIGINAL TO DELTA  
PLEASE PRINT CLEARLY -- YOUR ID CARD IS GENERATED FROM THIS FORM

### 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 Plan of Wisconsin, Inc., reserves the right to reject such an application