# ENROLLMENT/CHANGE/WAIVER FORM - Dental

**PLEASE NOTE THAT COMPLETING THIS FORM DOES NOT GUARANTEE COVERAGE.**

DELTA DENTAL®

**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 |
|---|---|---|---|---|---|
| | | | — — | / / | ❑ 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**

| LAST NAME | FIRST | M.I. | REL. CODE | STUDENT STATUS | DISABLED? (Y/N) | TAX DEP? (Y/N) | DATE OF BIRTH MO | DAY | YR |
|---|---|---|---|---|---|---|---|---|---|
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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 / DOMESTIC PARTNER

❑ 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 |
|---|---|---|---|
| | | | — — |

EMPLOYER NAME AND LOCATION

PLEASE CHECK ONE:

❑ I HAVE COVERAGE THROUGH MY SPOUSE

❑ I HAVE OTHER DENTAL COVERAGE

❑ I DO NOT HAVE OTHER DENTAL COVERAGE

❑ **Waive / Cancel 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.

For "Rel Code," use the following codes to describe the relationship of dependents to you:

| | |
|---|---|
| 01=Spouse | 24=Dependent of Your Minor Child |
| 15=Legal Ward | 38=Dependent of Domestic Partner |
| 17=Stepchild | 53=Domestic Partner |
| 19=Child | |

Completion of the Student Status column is required only if the dependent child(ren) are between the ages of 19 and 27. F=Full-time. P=Part-time. N=Not a student.

Indicate "Yes" or "No" if the dependent is disabled.

Indicate "Yes" or "No" if your domestic partner and/or dependent child is considered a tax dependent under federal law. You do not need to complete this box for your spouse. *Note: There may be tax consequences to you when you cover dependents (domestic partners and children) that are not dependent on you for at least 50% of their support.*