DELTA DENTAL®

Delta Dental of Wisconsin

Enrollment/Change/Waiver Form - Dental/Vision

PLEASE NOTE THAT COMPLETING THIS FORM DOES NOT GUARANTEE COVERAGE.

EMPLOYER USE ONLY

DENTAL GROUP NUMBER _____ _____ _____ _____ EFFECTIVE DATE _____

VISION 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)
				/ /

PLAN SELECTION (NOTE: You may enroll dependents only in plans that you enroll in)

SELECT PLAN(S) YOU WISH TO ENROLL IN: ☐ **DENTAL** ☐ **VISION**

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)
☐ DENTAL ☐ VISION						
☐ DENTAL ☐ VISION				☐	☐	
☐ DENTAL ☐ VISION				☐	☐	
☐ DENTAL ☐ VISION				☐	☐	
☐ DENTAL ☐ VISION				☐	☐	
☐ DENTAL ☐ VISION				☐	☐	
☐ DENTAL ☐ VISION				☐	☐	

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 DENTAL COVERAGE ARE YOU APPLYING FOR?

☐ Employee Only ☐ Employee & Spouse
☐ Employee & Child(ren) ☐ Entire Family

WHAT TYPE OF VISION 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: ☐ **DENTAL** ☐ **VISION**

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	EMPLOYER NAME

EMPLOYER LOCATION	CITY	STATE

IF WAIVING DENTAL PLEASE CHECK ONE:

- ☐ I have dental coverage through my spouse
- ☐ I have other dental coverage
- ☐ I do not have other dental coverage

IF WAIVING VISION PLEASE CHECK ONE:

- ☐ I have vision coverage through my spouse
- ☐ I have other vision coverage
- ☐ I do not have other vision coverage

WAIVE COVERAGE: ☐ **DENTAL** ☐ **VISION**

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/Vision 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/Vision 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.