## **ENROLLMENT/CHANGE/WAIVER FORM - Dental**

PLEASE NOTE THAT COMPLETING THIS FORM DOES NOT GUARANTEE COVERAGE.

 $\Delta$  delta dental°

EMPI	LOYI	ER U	SE (	ONLY

CROUP	NUMBER

EFFECTIVE DATE

COMPLETE THIS SECTION IF	OU ARE ACCE	PTING,	CHAN	IGING OR TERMI	NATING	G COV		יבי			
EMPLOYEE'S LAST NAME	FIRST		M.I.	SSN OR EMPLOYER-ASSIG		DATE DF	MO	DAY YR		SEX	
					1	BIRTH	/	/		F 🗖 M	
HOME ADDRESS - STREET				CITY				STATE		ZIP	
EMPLOYER NAME AND LOCATION (CITY & STATE)							DAT OF HIR		) DAY	YR /	
LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERI	ED					RELAT	IONSHIP	DA	FE OF BIF	RТН	
LAST NAME (IF DIFFERENT)		FIRST			M.I.	SON	DAU.	МО	DAY	YR	
SPOUSE											
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			)	WHAT TYPE OF COVERAGE ARE YOU APPLYING FOR?  EMPLOYEE ONLY EMPLOYEE & SPOUSE EMPLOYEE & ONE CHILD EMPLOYEE & CHILDREN ENTIRE FAMILY YOUR MARITAL STATUS SINGLE MARRIED							
ADD/ DOPD DEPENDENT (Name:	)			IF YOU ARE NOT ACCEPTIN ARE THEY COVERED BY AN				USE OR D YES 🗖		NTS,	
NAME CHANGE (Former Name:     ADDRESS CHANGE     GROUP TRANSFER (From to to)	,			Accept Cov	verage						
COBRA APPLICATION		SIGNATURE IS REQU			UIRED DATE						
COMPLETE THIS SECTION ONLY IF Y	OU ARE <b>WAIVING</b>	i COVER/	AGE								
EMPLOYEE'S LAST NAME	FIRST	М	.I. SSN	OR EMPLOYER-ASSIGNED ID	PLEAS	E CHE	CK ONE	1:			
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EMPLOYER NAME AND LOCATION					VE OTHEI						
						NOT HAV				GE	
<b>Waive Coverage</b> $X$	JATURE IS REQUIR	-D		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.