

# ENROLLMENT/CHANGE/WAIVER FORM - Dental

PLEASE NOTE THAT COMPLETING THIS FORM DOES NOT GUARANTEE COVERAGE.



## 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							RELATIONSHIP	DATE OF BIRTH		
LAST NAME (IF DIFFERENT)			FIRST	M.I.	SON	DAU.	MO	DAY	YR	
SPOUSE										

<p>REASON FOR SUBMITTING THIS FORM</p> <p>NEW ENROLLEE      REHIRE (Date:      )      DATE OCCURRED</p> <p>IF THIS IS FOR CHANGE, WHAT IS THE REASON?</p> <p>BIRTH/ADOPTION (Name:      )</p> <p>MARRIAGE/      DIVORCE</p> <p>ADD/      DROP DEPENDENT (Name:      )</p> <p>TERMINATION OF BENEFITS (Reason:      )</p> <p>LOSS OF BENEFITS</p> <p>NAME CHANGE (Former Name:      )</p> <p>ADDRESS CHANGE</p> <p>GROUP TRANSFER (From      to      )</p> <p>COBRA APPLICATION</p>	<p>WHAT TYPE OF COVERAGE ARE YOU APPLYING FOR?</p> <p>EMPLOYEE ONLY      EMPLOYEE &amp; SPOUSE      EMPLOYEE &amp; ONE CHILD</p> <p>EMPLOYEE &amp; CHILDREN      ENTIRE FAMILY      DEPENDENT TO AGE 19</p> <p>YOUR MARITAL STATUS      SINGLE      MARRIED</p> <p>IF YOU ARE NOT ACCEPTING COVERAGE FOR YOUR SPOUSE OR DEPENDENTS, ARE THEY COVERED BY ANOTHER DENTAL PLAN?      YES      NO</p> <p style="text-align: center; font-size: 24pt;"><b>Accept Coverage</b></p> <p><u>  X  </u> _____      _____</p> <p>SIGNATURE IS REQUIRED      DATE</p>
--	--

## COMPLETE THIS SECTION ONLY IF YOU ARE WAIVING COVERAGE

EMPLOYEE'S LAST NAME	FIRST	M.I.	SSN OR EMPLOYER-ASSIGNED	PLEASE CHECK ONE:
EMPLOYER NAME AND LOCATION				I HAVE OTHER DENTAL COVERAGE
				I DO NOT HAVE OTHER DENTAL COVERAGE
<p><b>Waive Coverage</b>      <u>  X  </u> _____      _____</p> <p>SIGNATURE IS REQUIRED      DATE</p>				

### 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.