



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	MO	DAY	YR	SEX	F	M
HOME ADDRESS - STREET			CITY	STATE	ZIP					
EMPLOYER NAME	EMPLOYER LOCATION	CITY	STATE	DATE OF HIRE	MO	DAY	YR			

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

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

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 _____ Date

Signature is Required

COMPLETE THIS SECTION ONLY IF YOU ARE WAIVING COVERAGE

EMPLOYEE LAST NAME	FIRST	M.I.	IF WAIVING DENTAL PLEASE CHECK ONE: <input type="checkbox"/> I have dental coverage through my spouse <input type="checkbox"/> I have other dental coverage <input type="checkbox"/> I do not have other dental coverage	IF WAIVING VISION PLEASE CHECK ONE: <input type="checkbox"/> I have vision coverage through my spouse <input type="checkbox"/> I have other vision coverage <input type="checkbox"/> I do not have other vision coverage
SSN OR EMPLOYER-ASSIGNED ID	EMPLOYER NAME			
EMPLOYER LOCATION	CITY	STATE		

WAIVE COVERAGE: DENTAL VISION X _____ Date

Signature is Required

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.