Wisconsin Insurance Benefit Trust
Enrollment/Change/Waiver Form - Dental/Vision

PLEASE NOTE THAT COMPLETING THIS FORM DOES NOT GUARANTEE COVERAGE.

Completed forms should be faxed or mailed to : Cyganiak Planning, Inc. - Do Not Send Forms To Delta Dental
3515 North 124th Street, Suite 100, Brookfield WI 53005 | Phone: 262-783-6161 | Fax: 262-783-5956

CYGANIAK PLANNING INC USE ONLY		Probationary Period	Agent Initials		
DENTAL COMPANY NUMBER				EFFECTIVE DATE	
VISION COMPANY 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 ADDRESS	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

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

WHAT TYPE OF VISION COVERAGE ARE YOU APPLYING FOR?

Employee Only Employee +1
Employee 2+

YOUR MARITAL STATUS Single Married

If you are not accepting coverage for your spouse or dependents, are they covered by another dental/vision 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