UWHC 2019 Open Enrollment
RESCIND PREVIOUS APPLICATION

DELTA DENTAL®

Delta Dental of Wisconsin

Return to Human Resources by Oct 26 deadline through an Ask HR case

State of Wisconsin – ETF Supplemental Dental Active Employee Enrollment Form

Employee ID _____

Please note that completing this form does not guarantee coverage

Plan Selection:

☐ Delta Dental PPO℠ – Select Plan ☐ Delta Dental PPO Plus Premier™ – Select Plus Plan

COMPLETE THIS SECTION IF YOU ARE ACCEPTING COVERAGE

EMPLOYEE LAST NAME	FIRST	M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH (M/D/Y) / /	GENDER F ☐ M ☐

HOME ADDRESS - STREET	CITY	STATE	ZIP

DATE OF HIRE / /

LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED

			GENDER		DATE OF BIRTH		
SPOUSE LAST NAME (IF DIFFERENT)	FIRST	M.I.	F ☐	M ☐			
CHILDREN/DEPENDENT LAST NAME (IF DIFFERENT)			☐	☐			
			☐	☐			
			☐	☐			
			☐	☐			
			☐	☐			
			☐	☐			

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 _____)	___/___/___

☐ I want to rescind my previous enrollment application

COVERAGE TYPE

WHAT TYPE OF COVERAGE ARE YOU APPLYING FOR?

☐ Self Only ☐ Self & Spouse
☐ Self & 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

☐ I DO NOT WANT TO ENROLL IN A DELTA DENTAL SELECT PLAN FOR 2019

X _____ _____
A handwritten signature is required Date

FOR EMPLOYER USE ONLY

Effective Date: 01/01/2019