THIS APPLICATION IS NOT FOR HEALTH INSURANCE WITH DENTAL. THIS APPLICATION IS ONLY FOR THE SUPPLEMENTAL DENTAL PLAN.

ENROLLMENT/CHANGE/WAIVER FORM - Dental

PLEASE NOTE THAT COMPLETING THIS FORM DOES NOT GUARANTEE COVERAGE.

DELTA DENTAL®

Supplemental Delta Dental (UWHC)

EMPLOYER USE ONLY — **NEW HIRE - EIT/RESIDENT**

GROUP NUMBER 103 EMPLOYEE ID: _____ 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

LAST NAME	FIRST	M.I.	REL. CODE	MARITAL STATUS	DISABLED? (Y/N)	TAX DEP? (Y/N)	DATE OF BIRTH 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	

WHAT TYPE OF COVERAGE ARE YOU APPLYING FOR?

❑ EMPLOYEE ONLY ❑ EMPLOYEE & SPOUSE

❑ EMPLOYEE & ONE CHILD ❑ EMPLOYEE & CHILDREN ❑ 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**

X _____ _____

SIGNATURE IS REQUIRED DATE

COMPLETE THIS SECTION **ONLY** IF YOU ARE **WAIVING** COVERAGE

EMPLOYEE'S LAST NAME	FIRST	M.I.	SSN OR EMPLOYER-ASSIGNED ID	PLEASE CHECK ONE:
			— —	❑ I HAVE COVERAGE THROUGH MY SPOUSE
EMPLOYER NAME AND LOCATION				❑ I HAVE OTHER DENTAL COVERAGE
				❑ I DO NOT HAVE OTHER DENTAL COVERAGE

❑ **Waive / Cancel Coverage** X _____ _____

SIGNATURE IS REQUIRED 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.

For "Rel Code," use the following codes to describe the relationship of dependents to you:

01=Spouse
15=Legal Ward
17=Stepchild
19=Child
24=Dependent of Your Minor Child

Indicate "Yes" or "No" if the dependent is married.

Indicate "Yes" or "No" if the dependent is disabled.

Indicate "Yes" or "No" if your domestic partner and/or dependent child is considered a tax dependent under federal law. You do not need to complete this box for your spouse. *Note: There may be tax consequences to you when you cover dependents (domestic partners and children) that are not dependent on you for at least 50% of their support.*

Return completed form to Human Resources: Upload to MedHub |