Dental Insurance Enrollment/Change/Waiver Form

DELTA DENTAL

PLEASE NOTE THAT COMPLETING THIS FORM DOES NOT GUARANTEE COVERAGE. THIS FORM MAY NOT BE USED FOR DELTA DENTAL'S TRISELECT VOLUNTARY OR DELTACARE PRODUCTS.

EMPLOYER USE ONLY	DANE COUNTY Group No. 704	EFFECTIVE DATE

COMPLETE THIS SECTION IF YOU ARE ACCEPTING, CHANGING OR TERMINATING COVERAGE

EMPLOYEE'S LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH: MO DAY YR
			– –	

HOME ADDRESS (STREET & NUMBER)	SEX: ☐ MALE ☐ FEMALE

CITY	STATE	ZIP CODE	DATE OF HIRE: MO DAY YR

LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED

CHECK ONE:	LAST NAME (IF DIFFERENT)	FIRST NAME	M.I.	RELATIONSHIP (i.e., son, stepson, etc.)	DATE OF BIRTH MONTH	DAY	YEAR
☐ SPOUSE ☐ DOMESTIC PARTNER							

REASON FOR SUBMITTING THIS FORM:

☐ New Enrollee ☐ Open Enrollment ☐ Change

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 _____
- ☐ COBRA Application _____

WHAT TYPE OF COVERAGE ARE YOU APPLYING FOR:

☐ EMPLOYEE ONLY ☐ FAMILY

MARITAL STATUS:

☐ SINGLE ☐ MARRIED ☐ DOMESTIC PARTNER

IF YOU ARE NOT ACCEPTING COVERAGE FOR YOUR SPOUSE OR YOUR DEPENDENTS, ARE THEY COVERED BY ANOTHER DENTAL PLAN?

☐ YES ☐ NO

ACCEPTANCE OF INSURANCE

SIGNATURE IS REQUIRED	DATE

COMPLETE THIS SECTION ONLY IF YOU ARE WAIVING COVERAGE

EMPLOYEE'S LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER
			– –

DEPARTMENT NAME

☐ WAIVE COVERAGE	SIGNATURE IS REQUIRED	DATE

PLEASE CHECK ONE:

- ☐ I have coverage through my spouse.
- ☐ I have other dental coverage.
- ☐ I do not have other dental coverage

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.

TERMS & CONDITIONS

1. To the best of my knowledge, all statements and answers in this application are complete and true.

2. My remitting agent is Dane County.

3. I agree to pay in advance the current premium for this insurance and I authorize the remitting agent to deduct from my wages or salary an amount sufficient to provide for regular premium payments that are not otherwise contributed. The remitting agent shall send the premium on my behalf to the insurance carrier I have selected.

4. I agree that any physician, hospital, or other institution, who attends or has attended me, my spouse, or any of my children is authorized to furnish the insurance carrier with any and all information including the history obtained, findings and diagnosis.