ENROLLMENT/CHANGE/WAIVER FORM

Delta Dental Plan of Wisconsin
PO Box 828
Stevens Point WI 54481
(800)236-3713

Please note that completing this form does not guarantee coverage

Group No:_____ Enrollment/Change Date:_____

Delta Premier Plan

Employee's Last Name	*First*	*M.I.*	*Social Security No.* - -	*Date of Birth*	*Sex* □ *F* □ *M*	*Date of Hire*

Home Address-Street	City	State	Zip

Employer and Location

What type of coverage are you applying for?

□ Employee only □ Employee & Spouse □ Employee & Children □ Family □ None (waive)

Your marital status

□ Single □ Married

At the time this plan becomes effective, will YOU be covered by any other dental plan? □ Yes □ No

Is YOUR SPOUSE covered by another dental plan? □ Yes □ No

Reason for submitting this form

□ New Enrollee □ Rehire (Date:_____) □ Birth/Adoption (Name_____) □ Marriage (Date:_____)
□ Divorce/Death of Spouse (Date:_____) □ Other (Please specify event & date:_____)

Have you had previous dental coverage? □ Yes □ No

*If yes, please list the name of the insurance company and the dates you were insured:_____
_____

List all eligible family members to be covered:

Last Name (if different)	First Name	MI	Relationship (spouse/son/daughter)	Date of Birth

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. I understand there will be a waiting period for some services if I have not had prior coverage for the past year.

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 application 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 Plan of Wisconsin, Inc., reserves the right to reject such application.

□ Accept Coverage □ Waive Coverage

X_____ _____
Signature is needed Date

*The plan will reduce your waiting period by the length of prior coverage you can show under a prior group or individual dental plan you have been covered under within 60 days of your date of hire with The Employer Group. Call The Employer Group for the required form of proof of coverage.