Signing this form to request coverage is also an election of pre-tax payroll deductions for the employee portion of the premiums.

ENROLLMENT/CHANGE/WAIVER FORM

PLEASE NOTE THAT COMPLETING THIS FORM DOES NOT GUARANTEE COVERAGE.

DELTA DENTAL

PLEASE PRINT CLEARLY -- YOUR ID CARD IS GENERATED FROM THIS FORM

DENTAL

EMPLOYER USE ONLY

GROUP NUMBER _____ _____ _____ _____ EFFECTIVE DATE _____

SECTION 1 - ENROLLEE INFORMATION

EMPLOYEE'S LAST NAME	FIRST	M.I.	SOCIAL SECURITY NO.	DATE OF BIRTH MO DAY YR	SEX
			— —	/ /	☐ F ☐ M

HOME ADDRESS - STREET	CITY	STATE	ZIP

EMPLOYER NAME AND LOCATION (CITY & STATE)
MCWAH Milwaukee, WI

DATE OF HIRE MO DAY YR / /

LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED

NO.	LAST NAME (IF DIFFERENT)	FIRST	M.I.	RELATIONSHIP SON	RELATIONSHIP DAU.	DATE OF BIRTH MO	DAY	YR
1	EMPLOYEE			—				
2	SPOUSE			—				
3								
4								
5								
6								

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 ☐ 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

AT THE TIME THIS PLAN BECOMES EFFECTIVE, WILL YOUR SPOUSE BE COVERED BY ANOTHER DENTAL PLAN?
☐ YES ☐ NO

☐ Accept Coverage ☐ Waive Coverage

SEE BELOW FOR PROVISIONS ON ACCEPTANCE OR WAIVER OF THESE BENEFITS.

SIGNATURE IS REQUIRED _____ DATE _____

SECTION 2: PLAN OPTIONS

Select one option only:

☐ **Freedom of Choice**
See a Delta Dental PPO, Delta Dental Premier or any other dentist, with out-of-pocket savings for seeing a Delta Dental PPO or Premier dentist. (Delta Dental PPO group #10302)

☐ **EPO (Exclusive Provider Option)**
Must see only Delta Dental PPO dentist.
(Exclusive Provider Option group #03905)

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