DELTA DENTAL®

Delta Dental of Wisconsin

State of Wisconsin – ETF Supplemental Dental Active Employee Enrollment Form

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_____)	___/___/___

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

☐ **ACCEPT COVERAGE**

X _____ _____
Signature is Required Date

FOR EMPLOYER USE ONLY

Effective Date: ___/___/___

Return To:
Your Human Resources Department