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 (Choose Preventive Plan and/or the Select or Select Plus Plan):

☐ Delta Dental PPO Plus Premier™ – Preventive Plan (option only available if **not** enrolling in health plan)

☐ Delta Dental PPO™ – Select Plan **OR** ☐ 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

LAST NAME (IF DIFFERENT)	FIRST	M.I.	GENDER F	GENDER M	DATE OF BIRTH M/D/Y
SPOUSE			☐	☐	/ /
CHILD/DEPENDENT			☐	☐	/ /
			☐	☐	/ /
			☐	☐	/ /
			☐	☐	/ /
			☐	☐	/ /
			☐	☐	/ /

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?

Preventive Plan (if not enrolled in health plan)

☐ Self Only ☐ Entire Family

Select or Select Plus Plan

☐ 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: / /

Received By: _____

Received Date: / /

Return To:
Your Human Resources Department