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

SPOUSE LAST NAME (IF DIFFERENT)	FIRST	M.I.	GENDER F ☐	GENDER M ☐	DATE OF BIRTH
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: ___/___/___
Received By: _____
Received Date: ___/___/___

Return To:
Your Human Resources Department