

SECTION 1: APPLICANT INFORMATION

Please provide your legal name, your spouse or domestic partner's name, your complete address where you want all your mail to be delivered, a daytime telephone number where you can be reached or a message can be left, date of birth, gender, and social security number or your current EPIC Dental Wisconsin customer number. This information insures accurate and timely enrollment and changes to your EPIC account.

Applicant Name (last, first, middle)		Spouse/Domestic Partner Name (last, first, middle)	
Street Address	City	State	Zip Code
Daytime Telephone Number	Date of Birth (MM/DD/CCYY)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number or Dental Wisconsin ID Number

SECTION 2: ENROLLMENT INFORMATION

Reason for Application (Check One):

- New Hire Qualifying Event Transfer
 Coverage Change Approved Enrollment Period
 Spouse to Spouse or Domestic Partner to Domestic Partner Coverage Transfer Cancel Coverage
 Loss of Other Group Dental Coverage Address Change Name Change

Plan (Check One):

- Dental PPO Select

Coverage Level:

- Employee Employee + Spouse/
 Employee + Child(ren) Domestic Partner
 Family

SECTION 3: LIST SPOUSE/DOMESTIC PARTNER/CHILD(REN) TO BE ENROLLED

(Use additional paper if needed to list all dependents)

Please list all eligible dependents that you wish to have covered under your plan, accurate information insures claims to be processed timely. Dependent children are eligible until the end of the month in which they turn 26.

If enrolling one dependent but dropping another, please complete two applications and staple them together.

Name	Date of Birth (MM/DD/CCYY)	Gender (M/F)	Social Security Number	Relationship to Applicant	Disabled (Y/N)	Tax Dep (Y/N)
		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

SECTION 4: CHANGE/ADD/CANCEL CURRENT COVERAGE

Subscriber Name Change to:

Add/Change Coverage Due to: <i>(list dependents you are adding in Section 3)</i>	Date	Cancel/Change Coverage Due to: <i>(list dependents you are adding in Section 3)</i>	Date
<input type="checkbox"/> Marriage		<input type="checkbox"/> Divorce/Termination of Domestic Partnership	
<input type="checkbox"/> Domestic Partnership Established		<input type="checkbox"/> Death of Spouse/Partner/Child	
<input type="checkbox"/> Addition of Children		<input type="checkbox"/> Loss of Dependent Eligibility	
<input type="checkbox"/> Other Change:		Explanation if Needed:	

SECTION 5: INFORMATION ABOUT OTHER COVERAGE (complete for all family members enrolling)

I have the following group insurance or had the following group insurance immediately prior to the anticipated effective date of this coverage:

- State of Wisconsin Group Health Insurance Name of Health Plan: _____
- Other Insurance: Type of Coverage: Health Dental Name(s) of All Other Plan(s): _____

My dependent(s) has other group coverage through an employer or had the following group insurance immediately prior to the anticipated effective date of this coverage:

- Yes No If yes, name of dependent(s): _____
- State of Wisconsin Group Health Insurance Name of Health Plan: _____
- Other Insurance: Type of Coverage: Health Dental Name(s) of All Other Plan(s): _____

SECTION 6: SIGNATURE – (Sign here and return completed application to your employer)

Please indicate if you are applying for coverage. Your signature and date are required to indicate that you are making a choice and that if electing coverage, you are authorizing payments to be deducted from your pay check.

- I apply for the coverage elected above. I understand that Wis. Stats. §943.395 provides criminal penalties for knowingly making false or fraudulent claims on this form and hereby certify that, to the best of my knowledge and belief, the information is true and correct. I agree to the provisions of the plan and hereby authorize deduction of the monthly premium from my salary. I understand that once enrolled this coverage must remain in force for the full calendar year unless eligibility is lost.

 I do not wish to enroll at this time.

- Cancel my coverage as of December 31, _____. I understand that I must submit the application to cancel coverage by December 1 or coverage will remain in force for the following calendar year unless eligibility is lost.

Applicant Signature

Date (MM/DD/CCYY)

FOR OFFICE USE ONLY

Date Rec'd	Received by	Hire Date	Cov Eff Date	Agency/Campus Code
EPIC Group Number 31800D	Division Number	Affidavit of domestic partnership on file <input type="checkbox"/> N/A <input type="checkbox"/> ETF Affidavit <input type="checkbox"/> Non "Chapter 40" Affidavit		Premium \$ _____

NOTE: RETURN THIS APPLICATION TO YOUR HUMAN RESOURCES DEPARTMENT.

Underwritten by The EPIC Life Insurance Company

29967-088-1609