



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 <input type="checkbox"/> <input type="checkbox"/>
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		DATE OF BIRTH M/D/Y / /
			F	M	
SPOUSE			<input type="checkbox"/>	<input type="checkbox"/>	/ /
CHILD/DEPENDENT			<input type="checkbox"/>	<input type="checkbox"/>	/ /
			<input type="checkbox"/>	<input type="checkbox"/>	/ /
			<input type="checkbox"/>	<input type="checkbox"/>	/ /
			<input type="checkbox"/>	<input type="checkbox"/>	/ /
			<input type="checkbox"/>	<input type="checkbox"/>	/ /
			<input type="checkbox"/>	<input type="checkbox"/>	/ /

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) / /

FOR EMPLOYER USE ONLY

Effective Date: / /

Received By: _____

Received Date: / /

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

× _____ / /
Signature is Required Date

Return To:
Your Human Resources Department