ENROLLMENT/CHANGE/WAIVER FORM - Dental PLEASE NOTE THAT COMPLETING THIS FORM DOES NOT GUARANTEE COVERAGE.



EMPLOYER USE ONLY										
GROUP NUMBER EFFECTIVE DATE										
COMPLETE THIS SECTION IF	YOU ARE ACCE	PTING,	CHAN	IGING OR TERMI	NATINO	S COV	ERAG	iΕ		建功
EMPLOYEE'S LAST NAME	FIRST		M.I.	SSN OR EMPLOYER-ASSIG	(DATE OF BIRTH	мо 1	DAY YR	8	SEX F \square M
HOME ADDRESS - STREET				CITY			ST	ATE	Z	IP
EMPLOYER NAME AND LOCATION (CITY & STATE) Hortonville Area School District	ct Hortonville, Wi			opennatudranura ezitek ziezudikakunurahilianur			DAT OF HIR		DAY	YR
LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVEL LAST NAME (IF DIFFERENT)	FIRST			RELATIO			DAT MO		OF BIRTH	
SPOUSE		FIRST			M.I.	SON	DAU.	MO	DAT	IK
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			nasaranan manan sa			1				
REASON FOR SUBMITTING THIS FORM NEW ENROLLEE REHIRE (Date:				WHAT TYPE OF COVERAGE ARE YOU APPLYING FOR? EMPLOYEE ONLY						
COMPLETE THIS SECTION ONLY IF	YOU ARE WAIVING	COVERA	\GE							
PLOYEE'S LAST NAME FIRST M.I. SSN PLOYER NAME AND LOCATION				R EMPLOYER-ASSIGNED ID — —	PLEASE CHECK ONE: I HAVE COVERAGE THROUGH MY SPOUSE I HAVE OTHER DENTAL COVERAGE I DO NOT HAVE OTHER DENTAL COVERAGE					
	NATURE IS REQUIRE	D		DATE				nan secondo		

Acceptance of Coverage

I accept the insurance provided by my employer's group insurance plan. I authorize deductions from my earnings for the required contributions toward the cost of insurance. (This authorization applies only if employee contributions are required.) I understand that by accepting insurance, I am required to remain enrolled as a covered employee and cannot make an elective change in the coverage selected until the next open enrollment period, if there is one provided for in the Master Agreement to Provide Dental Benefits.

Waiver of Coverage

I understand that if I decide not to apply for coverage, or if I apply only for single coverage even though I am eligible for family coverage, any subsequent application will be subject to the applicable terms and conditions of the Master Agreement to Provide Dental Benefits, which may require additional limitations and waiting periods. I also understand that Delta Dental of Wisconsin, Inc. reserves the right to reject such an application.