

Delta Dental of Wisconsin

State of Wisconsin – ETF Supplemental Dental Active Employee Enrollment Form

Please note that completing this form does not guarantee coverage

Pla	_				ct or Select Plus Plan only available if not enro		ı health	n plan)			
] Delta Dental PPO™	¹ - Select Plan	OR	Delta Der	ntal PPO Plus Premier™	- Select	t Plus F	Plan			
COMPLETI	E THIS SECTION I	F YOU ARE A	CCEPTING C	OVERAG	SE						
EMPLOYEE LAST NAME FIRST				M.I. SOCIAL SECURITY NUMBER			DATE OF BIRTH M/D/Y / /			GENDER F M	
HOME ADDRESS - STREET				CITY	ı		STATE			ZIP	
DATE OF HIF	RE / LIGIBLE FAMILY M	EMBERS TO B	E COVERED								
LAST NAME (IF DIFFERENT)			FIF	FIRST			GENDER D			ATE OF BIRTH M/D/Y	
SPOUSE									/	/	
CHILD/DEPE	ENDENT								/	/	
									/	/	
									/	/	
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REASON F	OR SUBMITTING	THIS FORM			OVERAGE TYPE						
NEW ENROLLEE REHIRE (Date:				Property See	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 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? ACCEPT COVERAGE Signature is Required Date						
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