Cedarburg School District

Challenging Students to Achieve Their Goals and Dreams

Insurance Application Information

Full-time employees (those who are scheduled to work at least 30 hours per week for the entire school year) are eligible for health and/or dental insurance. Applications for insurance benefits may be submitted by eligible employees:

1. upon being hired by the District;
2. during the annual open enrollment window (mid-November through early December);
3. within 30 days of a qualifying event (i.e., birth of a child, marriage, divorce, etc.).

Original completed application must be received by the payroll department in a timely manner.

Please direct questions to the Payroll/Benefits Office at extension 6113.

DELTA DENTAL®

Delta Dental of Wisconsin

Enrollment/Change/Waiver Form - Dental

PLEASE NOTE THAT COMPLETING THIS FORM DOES NOT GUARANTEE COVERAGE.

EMPLOYER USE ONLY

GROUP NUMBER 04015 000 00000 00000 EFFECTIVE DATE _____

COMPLETE THIS SECTION IF YOU ARE ACCEPTING, CHANGING, OR TERMINATING COVERAGE

EMPLOYEE LAST NAME	FIRST	M.I.	SSN OR EMPLOYER-ASSIGNED ID	DATE OF BIRTH MO DAY YR	SEX F M

HOME ADDRESS - STREET	CITY	STATE	ZIP

EMPLOYER NAME	EMPLOYER LOCATION	CITY	STATE	DATE OF HIRE MO DAY YR

LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED

SPOUSE LAST NAME (IF DIFFERENT)	FIRST	M.I.	RELATIONSHIP SON	RELATIONSHIP DAU.	DATE OF BIRTH MO	DAY	YR

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 _____)	
COBRA Application	

COVERAGE TYPE

WHAT TYPE OF COVERAGE ARE YOU APPLYING FOR?

Employee Only — Employee & Spouse

Employee & 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

COMPLETE THIS SECTION **ONLY** IF YOU ARE **WAIVING** COVERAGE

EMPLOYEE LAST NAME	FIRST	M.I.	SSN OR EMPLOYER-ASSIGNED ID	**PLEASE CHECK ONE:**
				I have coverage through my spouse I have other dental coverage I do not have other dental coverage

EMPLOYER NAME	EMPLOYER LOCATION	CITY	STATE

WAIVE COVERAGE

X _____ _____

Signature is Required — Date

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.