State of Wisconsin & University of Wisconsin System

GROUP DENTALBLUE APPLICATION

Please Print CLEARLY or Type

Check One Enrollment Type:

☐ New Hire ☐ Cancel
☐ Open Enrollment ☐ HIPAA
☐ Change/Move ☐ Waive
☐ Spouse to Spouse ☐ Transfer

☐ Check Here if WRS Retiree

Employee Last Name	**First Name**	**MI**	**Sex** ☐ F ☐ M	**Birthdate** (Mo/Day/Year)	**Social Security Number**
Street Address	**City**		**County**	**State**	**Zip**
Telephone Number (include area code)	**Marital Status:** ☐ Single ☐ Married ☐ Widow/Widower ☐ Divorced		**Original Hire Date**		
Domestic Partner Affidavit, if Applicable: ☐ Included with Application ☐ On File					
AGENCY/CAMPUS	**PLAN (check one):** ☐ Dentacare / HMO * Dental Center Selected _____ ☐ Preferred PPO ☐ Supplemental Plan** (See Medical Plan Requirement)		**COVERAGE DESIRED (check one):** ☐ Employee ☐ Employee Plus 1 ☐ Employee Plus 2 or more		

Important Notice:

*** Region 1: Milwaukee, Waukesha, Ozaukee, Washington, Racine and Kenosha Counties**
*** Region 2: All Wisconsin Counties not listed in Region 1 above**

****Supplemental Plan may only be selected if your Medical Plan provides a dental plan and you wish additional comprehensive dental benefits.**

Complete This Section If You Are Applying For Employee Plus 1 or Employee Plus 2 or More Coverage – List All Persons To Be Included

Last Name	**First Name**	**MI**	**Sex** (M or F)	**Date of Birth** (Mo/Day/Year)	**Student Over 19 Years**
Spouse/Domestic Partner:					
Dependent Children:					

Complete This Section If You Are Increasing or Decreasing Current Coverage

Name Under Which Contract Is Listed (Current Subscriber)		**Subscriber Number**	
Change From Employee Coverage To Family Coverage	**Date**	**Change From Family Coverage To Employee Coverage**	**Date**
☐ Marriage		☐ Divorce/Termination of Domestic Partnership	
☐ Addition of Dependents (Complete Family Coverage Section Above)		☐ Death of Spouse/Partner/Dependent	
☐ Domestic Partner		☐ Other (Specify)	
Explanation if Needed:			

Is Anyone Named In This Application Covered By Another Group Dental Insurance Program? (excludes EPIC) ☐ Yes (complete questions below) ☐ No

Name of Insured (Usually Your Spouse):	Insured's Employer:	
Name of Other Insurance Co. or Blue Cross & Blue Shield Plan:	Insured's Identification Number:	Account / Group Number:

Employee Signature: I certify all information provided is true and authorize the deduction of the required monthly premium.

X_____ Date_____

This Area For Office Use Only	Employer Contact Name:	Employer Contact Address:		
Employer Contact Phone No.:	Date Received by Employer	Cov. Eff. Date	If Applicable ☐ Region 1 ☐ Region 2	
Deduction Code / Premium Amt. / Agency/Campus Code	Group No. ☐ **93881** (State) ☐ **83445** (UW)	Original–Payroll/Benefits Office Copy 2–DentalBlue	Copy 1–Employee Copy 3–UW SC	