

**State of Wisconsin
&
University of
Wisconsin System**

GROUP DENTALBLUE APPLICATION

Please Print CLEARLY or Type
Submit completed form to your
agency/campus Payroll/Benefits office

- Check One Enrollment Type:
- New Hire
 - Open Enrollment
 - Change/Move
 - Spouse to Spouse
 - Cancel
 - HIPAA
 - Waive
 - Transfer
- Check Here if WRS Retiree

Employee Last Name	First Name	MI	Sex <input type="checkbox"/> F <input type="checkbox"/> M	Birthdate (Mo/Day/Year)	Social Security No.
Street Address		City		County	State Zip
Telephone Number (include area code)		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Divorced		Original Hire Date (if within the past year)	
Date of Domestic Partnership, if Applicable (date Dept of Employee Trust Funds rec'd Affidavit of Domestic Partnership): (Mo/Day/Year) Or <input type="checkbox"/> Filed with employer prior to 01/01/2010 on: (Mo/Day/Year)					
AGENCY/CAMPUS	PLAN (check one): <input type="checkbox"/> Dentacare / HMO * Dental Center Selected _____ <input type="checkbox"/> Preferred PPO <input type="checkbox"/> Supplemental Plan** (See Medical Plan Requirement)			COVERAGE DESIRED (check one): <input type="checkbox"/> Employee <input type="checkbox"/> Employee Plus 1 <input type="checkbox"/> 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 preventive and diagnostic dental benefits.

Complete This Section If You Are Applying For Employee Plus 1 or 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)	Federal Tax Dep+ (Y or N)
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		
<input type="checkbox"/> Marriage		<input type="checkbox"/> Divorce/Termination of Domestic Partnership			
<input type="checkbox"/> Domestic Partnership Established		<input type="checkbox"/> Death of Spouse/Partner/Dependent			
<input type="checkbox"/> Addition of Dependents (such as a federal non-tax dependent becomes a tax dependent+)		<input type="checkbox"/> Other (Specify).			
<input type="checkbox"/> Explanation If Needed:					

Employee Signature I certify all information provided is true and authorize the deduction of the required monthly premium. I understand that I must remain enrolled for the entire calendar year unless my employment terminates.
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 <input type="checkbox"/> Region 1 <input type="checkbox"/> Region 2
Deduction Code	Premium Amt.	Agency/Campus Code	Group No. <input type="checkbox"/> 93881 (State) <input type="checkbox"/> 83445 (UW)	Original-Payroll/Benefits Office Copy 2 –DentalBlue	Copy 1–Employee Copy 3 –UW SC

OSER/UW Application Rev. 09/09

+IMPORTANT TAX IMPLICATIONS if your dependent(s) include a domestic partner and his or children or your child who is over age 19 but under age 27: If you have indicated on this application that your domestic partner or your partner's eligible dependents or your child who is over age 19 but under age 27 are not considered "tax dependents" under federal law, the premiums will be taken on a post-tax basis. Definitions of eligible dependents for federal income tax purposes may be found in IRS Publication 501.