This is a fill-in form. Please click on the appropriate area to enter information. Tab between fields, PRINT when completed, then sign/date.

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** ☐ F ☐ M	**Birthdate** (Mo/Day/Year)	
Street Address	**City**		**County**	**State**	**Zip**
Telephone Number (include area code)	**Marital Status:** ☐ Single ☐ Married ☐ Domestic Partnership ☐ Divorced		**Original Hire Date** (if within the past year)		

Date of Domestic Partnership, if Applicable (choose one)
☐ Date Dept of Employee Trust Funds rec'd Affidavit of Domestic Partnership: (Mo/Day/Year)
Or: ☐ Filed with employer prior to 12/01/2009 on: (Mo/Day/Year)

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 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**
☐ Marriage		☐ Divorce/Termination of Domestic Partnership	
☐ Domestic Partnership Established		☐ Death of Spouse/Partner/Dependent	
☐ Addition of Dependents (such as a federal non-tax dependent becomes a tax dependent+)		☐ Other (Specify).	
☐ 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 ☐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

OSER/UW Application (OSER-DCLR-215 Rev. 09/2009)

+**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.

Submit completed form to your agency/campus payroll/benefits office

Print Form

Clear Form