

DENTAL INSURANCE ENROLLMENT FORM

CITY OF MILWAUKEE

A DENTAL PLAN NAME		DENTAL CENTER NUMBER		CLINIC NAME		
B YOUR LAST NAME		FIRST NAME	M.I.	GENDER	DATE OF BIRTH	9 DIGIT SSN (No Dashes)
				M <input type="checkbox"/> F <input type="checkbox"/>	/ /	
HOME ADDRESS			APT. #	CITY		STATE
						ZIP CODE
TELEPHONE NUMBER		6 DIGIT EMPLOYEE ID (Must be Indicated)		MARITAL STATUS		
				<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		
CITY START DATE		RETURN TO WORK DATE	JOB TITLE		DEPARTMENT	

C FAMILY COVERAGE ---- LIST ALL INDIVIDUALS TO BE INCLUDED					
LAST NAME	FIRST NAME	GENDER	DATE OF BIRTH mm/dd/yy	9 DIGIT SSN No Dashes	RELATIONSHIP: Spouse / Dependent / Domestic Partner / Adult Child / Other-- please indicate relationship
		M <input type="checkbox"/> F <input type="checkbox"/>	/ /		
		M <input type="checkbox"/> F <input type="checkbox"/>	/ /		
		M <input type="checkbox"/> F <input type="checkbox"/>	/ /		
		M <input type="checkbox"/> F <input type="checkbox"/>	/ /		
		M <input type="checkbox"/> F <input type="checkbox"/>	/ /		
		M <input type="checkbox"/> F <input type="checkbox"/>	/ /		
		M <input type="checkbox"/> F <input type="checkbox"/>	/ /		

D REASON FOR SUBMITTING ENROLLMENT FORM:					
<input type="checkbox"/> INITIAL ENROLLMENT	<input type="checkbox"/> ADD DEPENDENT	<input type="checkbox"/> DELETE SPOUSE / DOMESTIC PARTNER	Name:	DATE	/ /
<input type="checkbox"/> OPEN ENROLLMENT	<input type="checkbox"/> ADD ADULT CHILD	<input type="checkbox"/> DELETE ADULT CHILD / DEPENDENT	Name:	DATE	/ /
<input type="checkbox"/> RETURN TO WORK	<input type="checkbox"/> CLINIC CHANGE	<input type="checkbox"/> DEATH	Name:	DATE	/ /
<input type="checkbox"/> FAMILY TO SINGLE	<input type="checkbox"/> SINGLE TO FAMILY	<input type="checkbox"/> MARRIAGE	Maiden Name:	DATE	/ /
<input type="checkbox"/> OTHER		<input type="checkbox"/> DIVORCE	Name:	DATE	/ /

E IS ANYONE NAMED ON THIS ENROLLMENT FORM COVERED BY ANOTHER GROUP DENTAL INSURANCE PLAN?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
IF YES: NAME OF POLICYHOLDER (Usually your Spouse or Parent)		POLICYHOLDER'S EMPLOYER	
NAME OF INSURANCE COMPANY		POLICYHOLDER'S IDENTIFICATION NUMBER	

IS ANYONE NAMED ON THIS APPLICATION DISABLED, MENTALLY INCOMPETENT OR UNABLE TO PERFORM NORMAL WORK OR AGE-RELATED ACTIVITIES?
 YES NO If Yes, please indicate name: _____

X _____ / /

YOUR SIGNATURE	DATE SIGNED
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FOR OFFICE USE ONLY			
GROUP NUMBER	SECTION NUMBER	EMPLOYEE ID	UNION AFFILIATION
EFFECTIVE DATE	PAYROLL ADJUSTMENT DATA		

TERMS AND CONDITIONS

1. To the best of my knowledge, all statements and answers on this enrollment form are complete and true.
2. I agree to pay in advance the current premium for this dental insurance plan and I authorize the City of Milwaukee to deduct from my wages, salary, or pension an amount sufficient to provide for regular premium payments that are not otherwise contributed by the City.
3. I agree that any physician, dentist, hospital, or other health or dental care provider who attends or has attended me, my spouse, or any of my children covered by the dental insurance plan is authorized to furnish the plan, during a period extending to six months following the termination of my enrollment in the plan, with any information from patient dental or health care records for any purpose related to the plan.
4. I understand children listed on this enrollment form identified as "Dependent" are unmarried, and dependent on me, my spouse, or my former spouse for support and maintenance (as measured by standards employed by the IRS for determining dependency.) Further, I understand that children listed on this form between the ages of 18 and 26 who are not dependents as measured by standards employed by the IRS are considered "Adult Children." Any children listed over the age of 26 must be disabled so as to be incapable of self-support in order to remain on the policy.

NOTICE OF THIRTY DAY RULE

Every active and retired employee is responsible for keeping their enrollment status current.

You MUST notify Employee Benefits or the Employee's Retirement System of any change in status within 30 days.

This includes: birth, adoption, divorce, marriage (including marriage to another City employee), dependents/adult children who cease to be dependents or no longer meet the City's eligibility requirement, name change, or death of a covered individual.

New employees must complete health and dental enrollment forms within 30 days of their City start date to be eligible for coverage.

Employees returning to work must also complete health and dental enrollment forms within 30 days of their return-to-work date to be eligible for coverage.

Non compliance with the Thirty Day Rule exposes the City to additional costs for which you may be held responsible. There are no exceptions to this rule.