

DENTAL INSURANCE ENROLLMENT FORM

CITY OF MILWAUKEE

A SELECT A DENTAL PLAN				Desired Coverage			
Delta PPO <input type="checkbox"/> Delta EPO <input type="checkbox"/> Careplus <input type="checkbox"/>				Single <input type="checkbox"/> Family <input type="checkbox"/>			
B YOUR LAST NAME		FIRST NAME	M.I.	GENDER	DATE OF BIRTH		
				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	RELATIONSHIP: Spouse / Dependent / Domestic Partner / Adult Child / Other-- please indicate relationship
		M F <input type="checkbox"/> <input type="checkbox"/>	/ /	
		M F <input type="checkbox"/> <input type="checkbox"/>	/ /	
		M F <input type="checkbox"/> <input type="checkbox"/>	/ /	
		M F <input type="checkbox"/> <input type="checkbox"/>	/ /	
		M F <input type="checkbox"/> <input type="checkbox"/>	/ /	
		M F <input type="checkbox"/> <input type="checkbox"/>	/ /	
		M F <input type="checkbox"/> <input type="checkbox"/>	/ /	

D REASON FOR SUBMITTING ENROLLMENT FORM:			
<input type="checkbox"/> INITIAL ENROLLMENT	<input type="checkbox"/> ADD DEPENDENT	<input type="checkbox"/> DELETE SPOUSE	Name: _____ DATE: / /
<input type="checkbox"/> OPEN ENROLLMENT	<input type="checkbox"/> FAMILY TO SINGLE	<input type="checkbox"/> DELETE DEPENDENT	Name: _____ DATE: / /
<input type="checkbox"/> RETURN TO WORK	<input type="checkbox"/> SINGLE TO FAMILY	<input type="checkbox"/> DEATH	Name: _____ DATE: / /
<input type="checkbox"/> OTHER _____	<input type="checkbox"/> MARRIAGE (PROVIDE DATE)		Maiden Name: _____ DATE: / /
<input type="checkbox"/> NAME CHANGE From: _____ To: _____	<input type="checkbox"/> DIVORCE (PROVIDE DATE)		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
_____		_____

F Is Anyone Named On This Enrollment Form Disabled, Mentally Incompetent Or Unable To Perform Normal Work Or Age-Related Activities?	
YES <input type="checkbox"/> NO <input type="checkbox"/>	If Yes, please indicate name: _____

I apply for enrollment under the terms and conditions of my employer's Health Plan as administered by the entity stated in Section A and subject to the coverage rules and conditions on the reverse side. I understand that coverage is not effective until I have satisfied the health plan coverage eligibility criteria and rules. I authorize any payroll/pension deductions that may be necessary to cover the cost of my plan. To the best of my knowledge, all statements and answers in this application are complete and true and that any misrepresentation of coverage in this application may result in loss or denial of coverage for me and my dependents.

X _____	/ /
YOUR SIGNATURE	DATE SIGNED

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

Active Employees: Return completed form to Employee Benefits

Retirees: Return completed form to Employee's Retirement System.

Terms and Conditions

- To the best of my knowledge, all statements and answers on this enrollment form are complete and true and any misrepresentation of coverage in this application may result in loss or denial of coverage for me and my dependents.
- I authorize the City of Milwaukee to deduct from my wages, salary, or pension an amount sufficient to provide for regular dental premium payments that are not otherwise contributed by the City.
- I acknowledge that children listed on this enrollment form identified as “dependent” are under age 26 and eligible for coverage as measured by standards employed by the IRS for determining dependency. Any child listed as a dependent who is over the age of 26 must be disabled so as to be incapable of self-support in order to remain eligible for coverage.

Notice to Members Regarding the Thirty-One Day Rule for Health and Dental Plan Coverage

City of Milwaukee employees and retirees are responsible for keeping their enrollment status current and notifying the DER Employee Benefits Division or the Employees’ Retirement System (ERS) within 31 days of births, adoptions, marriages (including marriage to another City employee), divorces, changes in dependent eligibility status, deaths and Medicare coverage. Coverage for dependents is effective the date of the family status change provided members notify DER or ERS within 31 days of the event. Members must submit a copy of the marriage certificate, birth certificate and include social security numbers for each dependent enrolling in benefits. Non-compliance with coverage eligibility rules may expose members to additional costs or result in removal of dependents from the plan. There are no exceptions to this rule.

Enrollment Status and Changes

- City employees must use the City’s Self Service program www.milwaukee.gov/selfservice to make changes or updates to their enrollment status including address changes, births, adoptions and marriages. Employees must have their Employee ID number (6 digits) and a password to access self service. To request or reset a password visit www.milwaukee.gov/rits.
- City employees must fill out a paper enrollment form for any other status changes, such as divorce or removal of dependents.
- City employees returning to work must complete a health and dental enrollment form within 31 days of their return to work date.
- Agency employees must complete a health and dental enrollment form within 31 days of their start date and notify the appropriate agency of any other enrollment status changes within 31 days of the event.
- Retirees are responsible for keeping their enrollment status, including births, marriages, Medicare entitlement and other family status changes current by contacting ERS and completing the proper waiver or enrollment forms.

Compliance Notifications

Important legal notices, including HIPPA notice of privacy practices, affecting employee and retiree health plans are posted on DER’s benefits website www.milwaukee.gov/Benefits2018 under “L” Legal Notices.