

**SECTION 1: APPLICANT INFORMATION**

If you are a new employee with the State of WI within your eligibility period, please see your Benefits Personnel for a new employee application.

Please provide your legal name, your spouse or domestic partner's name, your complete address where you want all your mail to be delivered, a daytime telephone number where you can be reached or a message can be left, date of birth, gender, and social security number or your current EPIC Dental Wisconsin customer number. This information insures accurate and timely enrollment and changes to your EPIC account.

Applicant Name (last, first, middle)		Spouse/Domestic Partner Name (last, first, middle)	
Street Address	City	State	Zip Code
Daytime Telephone Number	Date of Birth (MM/DD/CCYY)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number or Dental Wisconsin ID Number

**SECTION 2: ENROLLMENT INFORMATION**

<b>Plan (Check One):</b> <input type="checkbox"/> Dental PPO <input type="checkbox"/> Select	<b>Coverage Level:</b> <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family	<input type="checkbox"/> Employee + Spouse/ Domestic Partner
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**SECTION 3: LIST SPOUSE/DOMESTIC PARTNER/CHILD(REN) TO BE ENROLLED**

(Use additional paper if needed to list all dependents)

Please list all eligible dependents that you wish to have covered under your plan, accurate information insures claims to be processed timely. **Dependent children are eligible until the end of the month in which they turn 26.**

If enrolling one dependent but dropping another, please complete two applications and staple them together.

Name	Date of Birth (MM/DD/CCYY)	Gender (M/F)	Social Security Number	Relationship to Applicant	Disabled (Y/N)	Tax Dep (Y/N)
		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

**SECTION 4: INFORMATION ABOUT OTHER COVERAGE (complete for all family members enrolling)**

This section is very important. For EPIC to review your 2016 dental benefits and waive any dental waiting period, this section needs to be completed. See Dental Wisconsin brochure for more information.

**I have the following group insurance or had the following group insurance immediately prior to the anticipated effective date of this coverage:**

- State of Wisconsin Group Health Insurance Name of Health Plan: \_\_\_\_\_
- Other Insurance: Type of Coverage:  Health  Dental Name(s) of All Other Plan(s): \_\_\_\_\_

**My dependent(s) has other group coverage through an employer or had the following group insurance immediately prior to the anticipated effective date of this coverage:**

- Yes  No If yes, name of dependent(s): \_\_\_\_\_
- State of Wisconsin Group Health Insurance Name of Health Plan: \_\_\_\_\_
- Other Insurance: Type of Coverage:  Health  Dental Name(s) of All Other Plan(s): \_\_\_\_\_

**I have the following EPIC coverage in 2016:**

- EPIC Benefits+
- EPIC Dental Wisconsin PPO
- EPIC Dental Wisconsin Select

**My dependents have the following EPIC coverage in 2016:**

- EPIC Benefits+
- EPIC Dental Wisconsin PPO
- EPIC Dental Wisconsin Select

**SECTION 5: SIGNATURE – (Sign here and return completed application to your employer)**

Please indicate if you are applying for coverage. Your signature and date are required to indicate that you are making a choice and that if electing coverage, you are authorizing payments to be deducted from your pay check.

I apply for the coverage elected above. I understand that Wis. Stats. §943.395 provides criminal penalties for knowingly making false or fraudulent claims on this form and hereby certify that, to the best of my knowledge and belief, the information is true and correct. I agree to the provisions of the plan and hereby authorize deduction of the monthly premium from my salary. I understand that once enrolled this coverage must remain in force for the full calendar year unless eligibility is lost.

Cancel my coverage as of December 31, 2017. I understand that I must submit the application to cancel coverage by December 1 or coverage will remain in force for the following calendar year unless eligibility is lost.

Applicant Signature

Date (MM/DD/CCYY)

**FOR OFFICE USE ONLY**

Date Rec'd	Received by	Hire Date	Cov Eff Date	Agency/Campus Code
EPIC Group Number	Division Number	Affidavit of domestic partnership on file <input type="checkbox"/> N/A <input type="checkbox"/> ETF Affidavit <input type="checkbox"/> Non "Chapter 40" Affidavit		Premium \$ _____

Underwritten by The EPIC Life Insurance Company

**NOTE: RETURN THIS APPLICATION TO YOUR HUMAN RESOURCES DEPARTMENT.**

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