EPIC™ SPECIALTY BENEFITS

DENTAL WISCONSIN FORM

Please print clearly or type - Submit completed form to your payroll/benefits office

SECTION 1: APPLICANT INFORMATION

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 ☐ Male ☐ Female	Social Security Number or Dental Wisconsin ID Number

SECTION 2: ENROLLMENT INFORMATION

Reason for Application (Check One):

☐ New Hire ☐ Qualifying Event ☐ Transfer
☐ Coverage Change ☐ Approved Enrollment Period
☐ Spouse to Spouse or Domestic Partner to Domestic Partner Coverage Transfer ☐ Cancel Coverage
☐ Loss of Other Group Dental Coverage ☐ Address Change ☐ Name Change

Plan (Check One):

☐ Dental PPO ☐ Select

Coverage Level:

☐ Employee
☐ Employee + Child(ren)
☐ Family
☐ Employee + Spouse/ Domestic Partner

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)
		☐ M ☐ F			☐ Y ☐ N	☐ Y ☐ N
		☐ M ☐ F			☐ Y ☐ N	☐ Y ☐ N
		☐ M ☐ F			☐ Y ☐ N	☐ Y ☐ N
		☐ M ☐ F			☐ Y ☐ N	☐ Y ☐ N
		☐ M ☐ F			☐ Y ☐ N	☐ Y ☐ N

Underwritten by The EPIC Life Insurance Company

SECTION 4: CHANGE/ADD/CANCEL CURRENT COVERAGE

Subscriber Name Change to:

Add/Change Coverage Due to: *(list dependents you are adding in Section 3)*	**Date**	**Cancel/Change Coverage Due to:** *(list dependents you are adding in Section 3)*	**Date**
☐ Marriage		☐ Divorce/Termination of Domestic Partnership	
☐ Domestic Partnership Established		☐ Death of Spouse/Partner/Child	
☐ Addition of Children		☐ Loss of Dependent Eligibility	
☐ **Other Change:**		**Explanation if Needed:**	

SECTION 5: INFORMATION ABOUT OTHER COVERAGE (complete for all family members enrolling)

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): _____

SECTION 6: 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.**

☐ **I do not wish to enroll at this time.**

☐ **Cancel my coverage as of December 31, _____. 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** ☐ N/A ☐ ETF Affidavit ☐ Non "Chapter 40" Affidavit		**Premium** $ _____

NOTE: RETURN THIS APPLICATION TO YOUR HUMAN RESOURCES DEPARTMENT.

Underwritten by The EPIC Life Insurance Company