



P.O. Box 19032, Green Bay, WI 54307-9032
(920) 661-6020

Dental Only Employee Enrollment



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(920) 661-1111 • (800) 232-5432

This is a: New Application Change to existing dental coverage

Employee Social Security Number

Group No.

Employer Name _____ Home Phone No. () _____

Last Name _____ First Name _____ Middle Initial _____

Home Address _____ City _____ State _____ ZIP _____

Gender: M F Date of Birth ____/____/____ Date Employed Full Time ____/____/____ Average Hours Worked Per Week _____

Yes No Are you currently disabled or hospital confined? If yes, explain _____

Yes No Are you or any family members covered by other dental insurance? If yes, list family members, the carrier and policy number: _____

Family Information (Only those applying for coverage)

| First Name & M.I. (last name if different) | Gender | Date of Birth | Social Security Number |
|--|---|---------------|------------------------|
| Spouse: | <input type="checkbox"/> M <input type="checkbox"/> F | / / | / / |
| Child: | <input type="checkbox"/> M <input type="checkbox"/> F | / / | / / |
| Child: | <input type="checkbox"/> M <input type="checkbox"/> F | / / | / / |
| Child: | <input type="checkbox"/> M <input type="checkbox"/> F | / / | / / |
| Child: | <input type="checkbox"/> M <input type="checkbox"/> F | / / | / / |

Dependents (age 19 and older) attending school full-time, include name of dependent, name/address of school, and no. of credits: _____

Dental Coverage & Waiver Information

Coverage: Employee Employee & Spouse Family Employee & Child(ren)
Dental Plan Selection: _____
Vision Benefit (if applicable): Exam Plus Prescription Eyewear

Waiver: I waive dental coverage for: Self (and dependents) Spouse Dependents

Please state reason for waiving coverage: _____

Yes No Is current Dental insurance being replaced? If yes, Effective date _____ Term date _____
Carrier name _____ Phone number () _____
Who was covered: _____ Reason for Termination _____

Yes No Did previous coverage include orthodontia?
 Yes No Have you had more than one Dental carrier in the past 12 months? If yes, please provide the above information for those carriers as well (you may use the back of this sheet).

Signature Required - Employee Agreement/Authorization to Release Information

I understand that the above answers are the basis for United Wisconsin Life Insurance Company (the "Insurer") to issue a certificate of insurance. I declare all statements in this form about myself and my dependents to be insured are true and correct to the best of my knowledge, and that no material information is withheld or omitted. I understand and agree that the Insurer is not bound by any statement made by or to any agent unless written herein. I agree that no insurance will be effective until the date specified by the Insurer in the certificate of insurance.

I hereby authorize any dentist or other dental professional to release to American Medical Security ("AMS") and/or the Insurer or their legal representative any and all such information with respect to diagnosis and treatment for any dental condition of me or my dependents to be insured. I understand that this authorization is valid for 2 1/2 years from the date below, the information obtained by use of this authorization may be used by the Insurer to determine eligibility for benefits, and that I may request copy of this authorization at any time. I agree that a photocopy of this authorization is as valid as the original. Any information obtained will not be released by the Insurer or AMS to any person or organization except to reinsuring companies or other persons or organizations performing business or legal services in connection with this enrollment, for any claim, or as may otherwise be lawfully required, or as I may further authorize.

If applicable, I authorize my employer to deduct the necessary contribution toward premium. I reserve the right to revoke this authorization at any time upon my written notice to my employer. This application will be part of the contract for insurance. Coverage is effective only after approval and satisfaction of any probationary period.

Any person who, knowingly and with intent to defraud any insurance company, submits an application or files a claim containing any materially false information may be found guilty in a court of law of insurance fraud, which is a crime, and may be subject to fines and confinement in prison. [Information on this application is valid for a maximum of 90 days from date of signature.](#)

I also hereby acknowledge receipt of the "Protecting Your Privacy" and "Protecting You Health Information" notices. I understand that I may request an additional copy of these notices at any time.

Employee Signature X _____ Date _____