

DENTAL ENROLLMENT FORM INSTRUCTIONS

City of Milwaukee
Department of Employee Relations
Employee Benefits Division

How To Complete DENTAL Plan Enrollment Form

GENERAL INSTRUCTIONS

1. Write the name of the DENTAL PLAN you selected in **Section A** from the list shown below under **SPECIFIC INSTRUCTIONS**.
2. Please read the **SPECIFIC INSTRUCTIONS** below for the Dental Plan of your choice.
3. Complete all sections of the DENTAL INSURANCE ENROLLMENT FORM as they apply to you. Failure to provide complete information will cause delays in setting up your membership and the issuance of I.D. cards. **Please note that a social security number is required for each dependent you are enrolling and a copy of a marriage certificate, adoption certificate or birth certificate is required when adding a dependent.** Certificates should be submitted with the enrollment form or if unavailable, forwarded within 30 days from the date of marriage, adoption or birth. Failure to submit documentation within 30 days may result in a loss of insurance coverage.
4. Return your completed enrollment form and applicable certificates to: **Department of Employee Relations, Employee Benefits Division, City Hall Room 706, 200 East Wells Street, Milwaukee, WI 53202. DO NOT** mail your completed form to the Dental Plans.
5. **DOMESTIC PARTNERS** – City employees must be in a registered Domestic Partnership to be eligible for this benefit. Domestic Partner medical benefits are available for some employee groups; call Employee Benefits at 286-3380 for additional information.

SPECIFIC INSTRUCTIONS

DELTA DENTAL

SECTION A – Write “**Delta Dental**” in DENTAL PLAN NAME. Check the box for either Single or Family in CONTRACT DESIRED.

CARE-PLUS

SECTION A – Write “**Care-Plus**” in DENTAL PLAN NAME. Check the box for either Single or Family in CONTRACT DESIRED.

DENTALBLUE

SECTION A – Write “**DentalBlue**” in DENTAL PLAN NAME box. Write the name of the DentalBlue clinic in CLINIC/OFFICE DESIRED box. Write the Center number in DENTAL CENTER/LOCATION # box. Check the box for either Single or Family in CONTRACT DESIRED. All family members must use the same clinic.

FIRST COMMONWEALTH/GUARDIAN

SECTION A – Write “**First Commonwealth**” in DENTAL PLAN NAME box. Write the Dental Office name in CLINIC/OFFICE DESIRED box. Write the Dental Office Location Number in DENTAL CENTER/LOCATION # box. Check the box for either Single or Family in CONTRACT DESIRED. Remember to write the name and dental location number for each dependent you enroll in Section C if different from information in Section A.

**PLEASE SIGN AND DATE YOUR ENROLLMENT FORM IN SECTION E
AFTER READING THE TERMS AND CONDITIONS**