Delta Dental of Wyoming
6234 Yellowstone Rd
Cheyenne, WY 82009
307-632-3313 * 800-735-3379
FAX 307-632-7309

Enrollment & Payroll Authorization Form

Last Name	First Name	Middle Initial	Social Security Number

Mailing Address	City	State	Zip

Group Name	Location	Job Title

Date of Birth	☐ Female ☐ Male	Date Hired

☐ Single ☐ Separated ☐ Married/Is spouse employed? ☐ No ☐ Yes Where? _____

☐ Divorced ☐ Widowed Does Spouse have a dental plan through employer? ☐ No ☐ Yes

List all eligible dependent's name's - Please Include Last Name if Different
(Please attach another page for additional names)

Spouse Name	Spouse's Date of Birth	☐ Female ☐ Male
Dependent Name	Dependent's Date of Birth	☐ Female ☐ Male
Dependent Name	Dependent's Date of Birth	☐ Female ☐ Male
Dependent Name	Dependent's Date of Birth	☐ Female ☐ Male
Dependent Name	Dependent's Date of Birth	☐ Female ☐ Male

I desire to be enrolled AS INDICATED BELOW, for the Group Dental Program offered by Delta Dental of Wyoming. PLEASE CHECK COVERAGE DESIRED: **(If enrolling one eligible dependent, all must be enrolled).** I agree to continue membership in this program during employment and while the program is in force and authorize payroll deductions if applicable.

☐ Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee, Spouse & Child(ren)

WAIVER OF COVERAGE

☐ I do not wish to cover myself (employee) as I have other Dental coverage.
Name of Dental Insurance Carrier: _____

☐ Employee coverage only/I do not wish to cover my spouse or children.

I understand that if I should decide to apply for coverage for myself or my dependents hereafter, such application shall be subject to the terms and conditions of the Master Contract which may require that I wait until open enrollment (unless there is a qualifying event) and there may also be additional limitations and waiting periods.

Date _____ Signature of Employee _____