EPIC SPECIALTY BENEFITS

2018 EPIC DENTAL WISCONSIN ANNUITANT SPECIAL ENROLLMENT FORM

Enrollment period of October 2 – October 27, 2017 | *Coverage Effective January 1, 2018*

Please print clearly or type - Submit form to EPIC Specialty Benefits

SECTION 1: APPLICANT INFORMATION

Member Name (last, first, middle)		Gender ☐ Male ☐ Female	Date of Birth
Street Address	City	State	Zip Code
Dental Wisconsin ID or Social Security Number	Email Address		Daytime Telephone Number

SECTION 2: PLAN SELECTION: (Check one)

Requested Coverage: ☐ Dental Wisconsin PPO ☐ Dental Wisconsin Select Plan

For Existing Members: ☐ Change Plan ☐ Cancel Coverage

SECTION 3: ENROLLMENT INFORMATION

Members enrolling during the 2018 Special Enrollment will be subject to the following **Dental Maximum benefit per member in calendar year:**

• 2018 is $600 • 2019 is $800 • 2020 is $1,250 (full benefit amount) • 24 month waiting period on Orthodontics

SECTION 4: COVERAGE TO BE SELECTED (Check one below)

Select which coverage fits your specific needs.

☐ Annuitant ☐ Annuitant + Spouse ☐ Annuitant + Child(ren) ☐ Family

SECTION 5: Complete the following information only for individuals covered by the policy.

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

Name	Date of Birth	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

SECTION 6: PREMIUM PAYMENT

This application for EPIC Dental WI Insurance must be submitted to EPIC no later than December 1, 2017. Premium payments for coverage will be billed by EPIC and paid to EPIC.

You may elect to receive and pay your premium by mail: ☐ Annually ☐ Semi-Annually ($2.00 fee) ☐ Quarterly ($2.00 fee)

You may elect to have premiums deducted directly from your bank through Electronic Fund Transfer:

☐ Semi-Annually ☐ Quarterly ☐ Monthly

From: ☐ Checking - Include a voided check

☐ Savings - Provide Account #_____ Routing # _____

Billing statements are not provided when electronic transfer is selected.

This authorization will remain in effect until I notify EPIC Specialty Benefits in writing of any changes. My notification must allow EPIC Specialty Benefits and my financial institution reasonable opportunity to discontinue premium deduction.

SECTION 7: SIGNATURE – (Sign here and return completed application to EPIC) PO Box 8430, Madison, WI 53708

☐ I am applying 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. **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 remain enrolled and pay required premium for the entire calender year. Termination of coverage due to nonpayment of premium may hinder future enrollment.**

Applicant Signature _____	**Date** _____

Underwritten by The EPIC Life Insurance Company