Human Resources Department
Madison Municipal Building, Suite 261
215 Martin Luther King, Jr. Boulevard
Madison, Wisconsin 53703
Phone: (608) 266-4615
Fax: (608) 267-1115
hr@cityofmadison.com
www.cityofmadison.com/hr

DENTAL INSURANCE AT RETIREMENT

Delta Dental

SECTION 1: CONTINUE DENTAL COVERAGE (Complete only if CONTINUING dental coverage at retirement)

Name _____ **Social Security Number** _____

Date of Retirement _____

☐ **I wish to continue my dental insurance in retirement and should be billed at the address below**:

Signature _____ **Date** _____

Mailing Address _____

City, State, Zip _____

Delta Dental Group Identification Number for Retired Continuants: **00502-200**

STOP HERE IF CONTINUING COVERAGE

SECTION 2: CANCEL DENTAL COVERAGE (Complete only if CANCELING dental coverage at retirement)

Name _____ **Social Security Number** _____

Date of Retirement _____

☐ **I wish to cancel my dental insurance when my active employee coverage ends**. I understand that no future enrollment opportunity will be available to me.

Signature _____ **Date** _____

SECTION 3: FOR EMPLOYER USE ONLY

Active Employee dental insurance premiums paid by payroll deduction through (date) _____

Original: Retiring Employee's Human Resources File

Copy: Retiring Employee