

# Enrollment/Change/Waiver Form - DeltaVision

PLEASE NOTE THAT COMPLETING THIS FORM DOES NOT GUARANTEE COVERAGE.

**EMPLOYER USE ONLY**

GROUP NUMBER \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_

**COMPLETE THIS SECTION IF YOU ARE ACCEPTING, CHANGING, OR TERMINATING COVERAGE**

EMPLOYEE LAST NAME	FIRST	M.I.	SSN OR EMPLOYER-ASSIGNED ID	DATE OF BIRTH (M/D/Y)	SEX F <input type="checkbox"/> M <input type="checkbox"/>
HOME ADDRESS - STREET			CITY	STATE	ZIP
EMPLOYER NAME	EMPLOYER LOCATION	CITY	STATE	DATE OF HIRE (M/D/Y)	

**LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED**

SPOUSE LAST NAME (IF DIFFERENT)	FIRST	M.I.	RELATIONSHIP		DATE OF BIRTH (M/D/Y)
			SON	DAU.	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	

**REASON FOR SUBMITTING THIS FORM**

NEW ENROLLEE     REHIRE (Date: \_\_\_\_\_)

**IF THIS IS FOR CHANGE, WHAT IS THE REASON?**      Date Occurred

Birth/Adoption (Name: \_\_\_\_\_)      \_\_\_\_\_

Marriage/ Divorce      \_\_\_\_\_

Add/ Drop Dependent (Name: \_\_\_\_\_)      \_\_\_\_\_

Termination of Benefits (Reason: \_\_\_\_\_)      \_\_\_\_\_

Loss of Vision Benefits      \_\_\_\_\_

Name Change (Former Name: \_\_\_\_\_)      \_\_\_\_\_

Address Change ( \_\_\_\_\_ )      \_\_\_\_\_

Group Transfer (From \_\_\_\_\_ To \_\_\_\_\_)      \_\_\_\_\_

COBRA Application      \_\_\_\_\_

**COVERAGE TYPE**

**WHAT TYPE OF COVERAGE ARE YOU APPLYING FOR?**

Employee Only       Employee & Spouse

Employee & Child(ren)       Entire Family

**YOUR MARITAL STATUS**       Single     Married

If you are not accepting coverage for your spouse or dependents, are they covered by another vision plan?

Yes     No

**ACCEPT COVERAGE**

X \_\_\_\_\_      \_\_\_\_\_

Signature is Required      Date

**COMPLETE THIS SECTION ONLY IF YOU ARE WAIVING COVERAGE**

EMPLOYEE LAST NAME	FIRST	M.I.	SSN OR EMPLOYER-ASSIGNED ID	PLEASE CHECK ONE:
EMPLOYER NAME	EMPLOYER LOCATION	CITY	STATE	<input type="checkbox"/> I have coverage through my spouse
				<input type="checkbox"/> I have other vision coverage
				<input type="checkbox"/> I do not have other vision coverage

**WAIVE COVERAGE**    X \_\_\_\_\_      \_\_\_\_\_

Signature is Required      Date

**Acceptance of Coverage**  
I accept the insurance provided by my employer's group insurance plan. I authorize deductions from my earnings for the required contributions toward the cost of insurance. (This authorization applies only if employee contributions are required.) I understand that by accepting insurance, I am required to remain enrolled as a covered employee and cannot make an elective change in the coverage selected until the next open enrollment period, if there is one provided for in the Master Agreement to Provide Vision Benefits.

**Waiver of Coverage**  
I understand that if I decide not to apply for coverage, or if I apply only for single coverage even though I am eligible for family coverage, any subsequent application will be subject to the applicable terms and conditions of the Master Agreement to Provide Vision Benefits, which may require additional limitations and waiting periods. I also understand that Delta Dental of Wisconsin, Inc. reserves the right to reject such an application.