DELTA DENTAL

Delta Dental of Wisconsin

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 ☐ M ☐

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 SON	RELATIONSHIP DAU.	DATE OF BIRTH (M/D/Y)
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	

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:**
				☐ I have coverage through my spouse ☐ I have other vision coverage ☐ I do not have other vision coverage

EMPLOYER NAME	EMPLOYER LOCATION	CITY	STATE

☐ **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.

DeltaVision is administered by Wyssta Insurance, a Delta Dental of Wisconsin Company, in conjunction with EyeMed Vision Care.