ENROLLMENT/CHANGE/WAIVER FORM - VISION

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'S LAST NAME	FIRST	M.I.	SSN OR EMPLOYER-ASSIGNED ID	DATE OF BIRTH MO DAY YR	SEX
			— —	/ /	☐F ☐M

HOME ADDRESS - STREET	CITY	STATE	ZIP

EMPLOYER NAME AND LOCATION (CITY & STATE)	DATE OF HIRE MO DAY YR
	/ /

LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED LAST NAME (IF DIFFERENT)	FIRST	M.I.	RELATIONSHIP SON	 DAU.	DATE OF BIRTH MO	 DAY	 YR
SPOUSE							

REASON FOR SUBMITTING THIS FORM

☐ NEW ENROLLEE ☐ REHIRE Date: ☐

IF THIS IS FOR CHANGE, WHAT IS THE REASON?

BIRTH/ADOPTION Name:

☐ MARRIAGE ☐ DIVORCE

☐ ADD/DROP DEPENDENT Name:

☐ TERMINATION OF BENEFITS Reason: ☐

☐ LOSS OF BENEFITS

☐ NAME CHANGE Former Name: ☐

DATE OCCURRED

☐

☐

☐

☐

☐

☐

WHAT TYPE OF COVERAGE ARE YOU APPLYING FOR?

☐ EMPLOYEE ONLY ☐ EMPLOYEE & SPOUSE

☐ EMPLOYEE & CHILDREN ☐ ENTIRE FAMILY

YOUR MARITAL STATUS ☐ SINGLE ☐ MARRIED

IF YOU ARE NOT ACCEPTING COVERAGE FOR YOUR SPOUSE OR DEPENDENTS, ARE THEY COVERED BY ANOTHER DENTAL PLAN? ☐ YES ☐ NO

☐ Accept Coverage

X _____ _____

SIGNATURE IS REQUIRED DATE

COMPLETE THIS SECTION ONLY IF YOU ARE WAIVING COVERAGE

EMPLOYEE'S LAST NAME	FIRST	M.I.	SSN OR EMPLOYER-ASSIGNED	PLEASE CHECK ONE:
			— —	I HAVE COVERAGE THROUGH MY SPOUSE
EMPLOYER NAME AND LOCATION				I HAVE OTHER DENTAL COVERAGE
				I DO NOT HAVE OTHER DENTAL 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.dEL

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