VISION INSURANCE

ENROLLMENT/CHANGE/WAIVER FORM

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
Oak Creek-Franklin Joint School District	/ /

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: DATE OCCURRED

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:

WHAT TYPE OF COVERAGE ARE YOU APPLYING FOR?

EMPLOYEE ONLY EMPLOYEE & SPOUSE

EMPLOYEE & CHILDREN ENTIRE FAMILY

YOUR MARITAL STATUS SINGLE MARRIED

Accept Coverage

X ______________________________ ________

SIGNATURE IS REQUIRED DATE

COMPLETE THIS SECTION ONLY IF YOU ARE WAIVING COVERAGE

EMPLOYEE'S LAST NAME	FIRST	M.I.

EMPLOYER NAME

Oak Creek-Franklin Joint School District

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.

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