DELTA DENTAL®

DeltaVision®

Delta Dental of Wisconsin

# ETF Supplemental Vision Retiree/Continuant Change Form

Please note that completing this form does not guarantee coverage

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

| SUBSCRIBER LAST NAME | FIRST | M.I. | SOCIAL SECURITY NUMBER | DATE OF BIRTH M/D/Y | GENDER F ☐ M ☐ |
|---|---|---|---|---|---|
| | | | | | |

| HOME ADDRESS – STREET | CITY | STATE | ZIP |
|---|---|---|---|
| | | | |

| PHONE NUMBER |
|---|
| |

### LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED

| SPOUSE LAST NAME (IF DIFFERENT) | FIRST | M.I. | GENDER F ☐ | GENDER M ☐ | DATE OF BIRTH (M/D/Y) |
|---|---|---|---|---|---|
| CHILD/DEPENDENT LAST NAME (IF DIFFERENT) | | | ☐ | ☐ | |
| | | | ☐ | ☐ | |
| | | | ☐ | ☐ | |
| | | | ☐ | ☐ | |
| | | | ☐ | ☐ | |
| | | | ☐ | ☐ | |

## BILLING

**HOW WOULD YOU LIKE TO BE BILLED?**

☐ **Auto Pay:** Set up monthly payment from your saving or checking account. Payments will be drawn on the fifth of each month.

Name of Financial Institution _____

Type of Account (Choose one) ☐ Checking ☐ Savings

Bank Routing Number _____

Bank Account Number _____

In addition, Please attach a voided check

By checking Auto Pay above I hereby authorize Delta Dental of Wisconsin to initiate debit entries on my account and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my account and the financial institution I have indicated above. The authority is to remain in full force and effect until Delta Dental of Wisconsin has received written notification from me of its termination in such time and in such manner to afford Delta Dental of Wisconsin and my financial institution a reasonable opportunity to act upon it.

☐ **Bill Me:** Receive a paper invoice monthly and pay by check. Paper invoices are mailed each month on the fifteenth with payment due on the first.

☐ **WRS (Wisconsin Retirement System) Annuity:** The monthly premium will be deducted by WRS from my annuity (provided funds are available).

## REASON FOR SUBMITTING THIS FORM

| | Date Occurred |
|---|---|
| ☐ Open Enrollment* – New Enrollee | |
| ☐ Birth/Adoption (Name: _____ ) | _____ |
| ☐ Marriage/ ☐ Divorce | _____ |
| ☐ Add/ ☐ Drop Dependent (Name: _____ ) | _____ |
| ☐ Cancellation of Benefits (Reason: _____ ) | _____ |
| ☐ Loss of Vision Benefits | _____ |
| ☐ Name Change (Former Name: _____ ) | _____ |
| ☐ Address Change ( _____ ) | _____ |

## COVERAGE TYPE

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

**Vision Plan**

☐ Self Only ☐ Self & Spouse

☐ Self & Child(ren) ☐ Entire Family

**APPLICATION TYPE**

☐ Retiree ☐ Continuant

☐ ACCEPT COVERAGE ☐ WAIVE COVERAGE

Signature is Required X _____ Date _____

*__Note:__ Open enrollment changes must be postmarked by October 20, 2023

__Return To:__ Delta Dental of Wisconsin
P.O. Box 86 Stevens Point, WI 54481
Phone: 844-337-8383

DeltaVision is underwritten by Wyssta Insurance Company.