DELTA DENTAL®

DeltaVision®

Delta Dental of Wisconsin
ETF Supplemental Vision Retiree/Continuant Enrollment Form

Please note that completing this form does not guarantee coverage

COMPLETE THIS SECTION IF YOU ARE ACCEPTING COVERAGE

EMPLOYEE LAST NAME	EMPLOYEE FIRST, M.I.	APPLICANT LAST NAME (IF DIFFERENT THAN EMPLOYEE)	APPLICANT FIRST, M.I.	
APPLICANT SOCIAL SECURITY NUMBER		APPLICANT DATE OF BIRTH	GENDER ☐ Female ☐ Male	
APPLICANT HOME ADDRESS - STREET		CITY	STATE	ZIP
APPLICANT PHONE NUMBER				

LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED

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

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**

X _____ _____

Signature is Required Date

NOTE: This application must be submitted to Delta Dental of Wisconsin within 60 days of the 'Date of Notice' in the Employer Use Only section. Plan selection may only be changed at Open Enrollment. For more information about the length of your continuation coverage contact ETF at 1-877-533-5020

EMPLOYER USE ONLY

Date of Notice _____

Eligibility Date _____

Continuation End Date _____

Employer Name _____

REASON

☐ End of employment (enter end date) _____

☐ Retirement (enter retirement date) _____

☐ Divorce (enter event date) _____

☐ Dependent no longer eligible (enter event date) _____

☐ Other (explain) _____

COMPLETED BY

_____

DeltaVision is underwritten by Wyssta Insurance Company.

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