DELTA DENTAL®

Delta Dental of Wisconsin

State of Wisconsin – ETF Supplemental Dental Retiree Open Enrollment Form

Please note that completing this form does not guarantee coverage

Plan Selection (Choose Preventive Plan and/or the Select or Select Plus Plan):

☐ Delta Dental PPO Plus Premier™ – Preventive Plan (option only available if **not** enrolling in health plan)

☐ Delta Dental PPO™ – Select Plan **OR** ☐ Delta Dental PPO Plus Premier™ – Select Plus Plan

COMPLETE THIS SECTION IF YOU ARE ACCEPTING COVERAGE

RETIREE 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.

COVERAGE TYPE

WHAT TYPE OF COVERAGE ARE YOU APPLYING FOR?

Preventive Plan (if not enrolled in health plan)

☐ Self Only ☐ Entire Family

Select or Select Plus Plan

☐ Self Only ☐ Self & Spouse

☐ Self & Child(ren) ☐ Entire Family

☐ **ACCEPT COVERAGE**

X _____ / / _____

Signature is Required Date

Return To:

Delta Dental of Wisconsin | PO Box 828 | Stevens Point, WI 54481 | Phone: 844-337-8383

by October 23, 2020

Or apply online at www.deltadentalwi.com/state-of-wi/enroll