DELTA DENTAL®

# Vision Insurance

**Dane County Retirees Direct Billed**

# 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

| RETIREE'S LAST NAME | FIRST | M.I. | SOCIAL SECURITY NUMBER | DATE OF BIRTH MO DAY YR | SEX |
|---|---|---|---|---|---|
| | | | — — | / / | ❑ F ❑ M |

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

| | |
|---|---|
| SPOUSE'S NAME (REQUIRED ONLY IF YOUR ARE APPLYING FOR COVERAGE FOR YOUR SPOUSE) | DATE OF BIRTH MO DAY YR / / |
| DEPENDENT'S NAME (REQUIRED ONLY IF YOUR ARE APPLYING FOR FAMILY COVERAGE) | DATE OF BIRTH MO DAY YR / / |
| | DATE OF BIRTH MO DAY YR / / |
| | DATE OF BIRTH MO DAY YR / / |

WHAT TYPE OF COVERAGE ARE YOU APPLYING FOR? ❑ RETIREE ONLY ❑ RETIREE & SPOUSE ❑ RETIREE & CHILDREN ❑ ENTIRE FAMILY

YOUR MARITAL STATUS: ❑ SINGLE ❑ MARRIED

IF YOU ARE NOT ACCEPTING COVERAGE FOR YOUR SPOUSE, ARE THEY COVERED BY ANOTHER VISION PLAN? ■ YES ❑ NO

TYPE OF COVERAGE: ❑ EXAM PLAN(43707) ❑ NO EXAM PLAN (43706)

❑ **Accept 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.

Special Note
To terminate coverage contact: *Delta Dental of Wisconsin*
*PO Box 828, Stevens Point, WI 54481*
*1-888-324-8600*

**To pay for your coverage through direct deposit, complete the information on the opposite side of this form.**

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

**MONTHLY/QUARTERLY ELECTRONIC FUNDS TRANSFER (EFT)**

**AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS**

I hereby authorize Delta Dental of Wisconsin, Inc. to initiate debit entries on the 5th of each month for monthly billed and the first week of the quarter for quarterly billed and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my account and the financial institution indicated below.

Name of financial institution | City, State, Zip

Transit/ABA number | Account number

Type of account (select one) _____ Checking _____ Savings

**(Please attach a voided check).**

This authorization is to remain in full force and effect until Delta Dental has received written notification from me of its termination in such time and in such manner as to afford Company and Depository a reasonable opportunity to act on it.

Subscriber name (please print)

Subscriber signature | Date

Subscriber identification number | Subscriber telephone number

**YOUR ACCOUNT MUST BE PAID IN FULL PRIOR TO YOUR FIRST EFT TRANSFER.**

Please return your payment, billing invoice and this completed form to:


Delta Dental of Wisconsin • Enrollment/Billing Department
P.O. Box 828, Stevens Point, WI 54481
888-324-8600 • Fax 715-343-7609