DELTA DENTAL®

DeltaVision®

Delta Dental of Wisconsin

State of Wisconsin – ETF Supplemental Vision Active Employee Enrollment Form

Please note that completing this form does not guarantee coverage

COMPLETE THIS SECTION IF YOU ARE ACCEPTING COVERAGE

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

HOME ADDRESS – STREET	CITY	STATE	ZIP

DATE OF HIRE
/ /

LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED

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

REASON FOR SUBMITTING THIS FORM

☐ NEW ENROLLEE ☐ REHIRE (Date: ___/___/___)

IF THIS IS FOR CHANGE, WHAT IS THE REASON?

	Date Occurred
☐ Birth/Adoption (Name: _____)	___/___/___
☐ Marriage/ ☐ Divorce	___/___/___
☐ Add/ ☐ Drop Dependent (Name: _____)	___/___/___
☐ Termination 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

☐ ACCEPT COVERAGE

X _____ ___/___/___

Signature is Required Date

FOR EMPLOYER USE ONLY

Effective Date: ___/___/___ Received By: _____ Received Date: ___/___/___

DeltaVision is underwritten by Wyssta Insurance Company.

Return To:
Your Human Resources Department