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, CHANGING, OR TERMINATING 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: _____) _____
- ☐ Cancellation of Benefits (Reason: _____) _____
- ☐ Loss of Vision Benefits _____
- ☐ Name Change (Former Name: _____) _____
- ☐ Address Change (_____) _____
- ☐ Group Transfer (From _____ To _____) _____

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: _____

Employer Name: _____

DeltaVision is underwritten by Wyssta Insurance Company.

Return To:
Your Human Resources Department