



DeltaVision®

# Delta Dental of Wisconsin State 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 <small>(IF DIFFERENT THAN EMPLOYEE)</small>	APPLICANT FIRST, M.I.
APPLICANT SOCIAL SECURITY NUMBER		APPLICANT DATE OF BIRTH	GENDER <input type="checkbox"/> Female <input type="checkbox"/> Male
APPLICANT HOME ADDRESS - STREET		CITY	STATE <span style="float:right">ZIP</span>
APPLICANT PHONE NUMBER			

## LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED

SPOUSE LAST NAME (IF DIFFERENT)	FIRST	M.I.	GENDER		DATE OF BIRTH (M/D/Y)
			F	M	
CHILD/DEPENDENT LAST NAME (IF DIFFERENT)			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	

## 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	REASON	COMPLETED BY
Date of Notice _____	<input type="checkbox"/> End of employment (enter end date) _____	_____
Eligibility Date _____	<input type="checkbox"/> Retirement (enter retirement date) _____	
Continuation End Date _____	<input type="checkbox"/> Divorce (enter event date) _____	
Employer Name _____	<input type="checkbox"/> Dependent no longer eligible (enter event date) _____	
	<input type="checkbox"/> Other (explain) _____	