

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 <input type="checkbox"/> F <input type="checkbox"/> 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.**

**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**

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