ENROLLMENT/CHANGE/WAIVER FORM - DeltaVision

NOTE: COMPLETING THIS FORM DOES NOT GUARANTEE COVERAGE.

EMPLOYER USE ONLY

GROUP NUMBER _____ _____ _____ _____ EFFECTIVE DATE _____

ENROLLEES MUST COMPLETE THIS SECTION

EMPLOYEE'S LAST NAME	FIRST	M.I.	SOCIAL SECURITY NO.	DATE OF BIRTH MO DAY YR	SEX
			— —	/ /	❑ F ❑ M

HOME ADDRESS - STREET	CITY	STATE	ZIP

EMPLOYER NAME AND LOCATION (CITY & STATE)	DATE OF HIRE MO DAY YR
	/ /

LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED				RELATIONSHIP		DATE OF BIRTH		
NO.	LAST NAME (IF DIFFERENT)	FIRST	M.I.	SON	DAU.	MO	DAY	YR
1	EMPLOYEE			—				
2	SPOUSE			—				
3								
4								
5								
6								

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: _____)	_____
❑ NAME CHANGE (Former Name: _____)	_____
❑ ADDRESS CHANGE _____	
❑ GROUP TRANSFER (From _____ to _____)	_____
❑ COBRA APPLICATION	_____

WHAT TYPE OF COVERAGE ARE YOU APPLYING FOR?

❑ EMPLOYEE ONLY ❑ EMP. + ONE ❑ EMP. & TWO OR MORE ❑ NONE (WAIVE)

YOUR MARITAL STATUS

❑ SINGLE ❑ MARRIED

AT THE TIME THIS PLAN BECOMES EFFECTIVE, WILL YOU BE COVERED BY ANY OTHER VISION PLAN?

❑ YES ❑ NO

AT THE TIME THIS PLAN BECOMES EFFECTIVE, WILL YOUR SPOUSE BE COVERED BY ANOTHER VISION PLAN?

❑ YES ❑ NO

❑ **Accept Coverage** ❑ **Waive Coverage**

SEE BELOW FOR PROVISIONS ON ACCEPTANCE OR WAIVER OF THESE BENEFITS.

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.

Waiver of Coverage

I understand that if I decide not to apply for coverage, or if I apply only for single coverage even though I am eligible for family coverage, any subsequent application will be subject to the applicable terms and conditions of the Master Agreement to Provide Vision Benefits, which may require additional limitations and waiting periods. I also understand that Wyssta Insurance reserves the right to reject such an application.

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