



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 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: _____