



# Delta Dental of Wisconsin Application

## GROUP INFORMATION

Employer (Group) \_\_\_\_\_

Address \_\_\_\_\_  
Street P.O. Box City State ZIP

Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Fax ( ) \_\_\_\_\_ - \_\_\_\_\_

Nature of business \_\_\_\_\_ Years in business \_\_\_\_\_ SIC code \_\_\_\_\_

Current vision carrier \_\_\_\_\_ How long? \_\_\_\_\_

Benefit contact name \_\_\_\_\_ Title \_\_\_\_\_ Email \_\_\_\_\_

Billing contact name \_\_\_\_\_ Title \_\_\_\_\_ Email \_\_\_\_\_

Billing delivery method:  Paper  Fax  Email - specify email address \_\_\_\_\_

Joint billing with Delta Dental dental plan?  Yes  No

## PLAN DESIGN

Network:  Access  Select Benefit Plan Type:  A  H

(Choose one plan, then fill in plan benefits.)

**Comprehensive Plan** (Please refer to your proposal to fill in plan benefits.)

Allowance \_\_\_\_\_ / \_\_\_\_\_ (Frames / Contact Lenses)

Copay \_\_\_\_\_ / \_\_\_\_\_ (Exams / Standard Plastic Lenses)

Frequency \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (Exams / Lenses or Contact Lenses / Frames)

**Materials-Only Plan Allowance** (Please refer to your proposal to check plan allowance.)

\$150 \_\_\_\_\_

\$200 \_\_\_\_\_

\$250 \_\_\_\_\_

**Nonstandard Plan** (Please refer to your proposal to fill in plan benefits.)

Allowance \_\_\_\_\_ / \_\_\_\_\_ (Frames / Contact Lenses)

Copay \_\_\_\_\_ / \_\_\_\_\_ (Exams / Standard Plastic Lenses)

Frequency \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (Exams / Lenses or Contact Lenses / Frames)

