

ENROLLMENT/CHANGE/WAIVER FORM - DeltaVision

NOTE: 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

EMPLOYEE'S LAST NAME	FIRST	M.I.	SOCIAL SECURITY NO. — —	DATE OF BIRTH MO DAY YR / /	SEX <input type="checkbox"/> F <input type="checkbox"/> 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	
LAST NAME (IF DIFFERENT)	FIRST	M.I.	SON DAU.	MO	DAY YR
SPOUSE					

REASON FOR SUBMITTING THIS FORM

NEW ENROLLEE REHIRE (Date: _____)

IF THIS IS FOR CHANGE, WHAT IS THE REASON?

- BIRTH/ADOPTION (Name: _____)
- MARRIAGE/ DIVORCE
- ADD/ DROP DEPENDENT (Name: _____)
- TERMINATION OF BENEFITS (Reason: _____)
- LOSS OF VISION BENEFITS
- NAME CHANGE (Former Name: _____)
- ADDRESS CHANGE
- GROUP TRANSFER (From _____ to _____)
- COBRA APPLICATION

DATE OCCURRED

WHAT TYPE OF COVERAGE ARE YOU APPLYING FOR?

- EMPLOYEE ONLY EMPLOYEE & SPOUSE EMPLOYEE & ONE CHILD
 EMPLOYEE & CHILDREN ENTIRE FAMILY

YOUR MARITAL STATUS SINGLE MARRIED

IF YOU ARE NOT ACCEPTING COVERAGE FOR YOUR SPOUSE OR DEPENDENTS, ARE THEY COVERED BY ANOTHER VISION PLAN? YES NO

Accept Coverage

SIGNATURE IS REQUIRED _____

DATE _____

COMPLETE THIS SECTION ONLY IF YOU ARE WAIVING COVERAGE

EMPLOYEE'S LAST NAME	FIRST	M.I.	SOCIAL SECURITY NO. — —	PLEASE CHECK ONE:
EMPLOYER NAME AND LOCATION				<input type="checkbox"/> I HAVE COVERAGE THROUGH MY SPOUSE
				<input type="checkbox"/> I HAVE OTHER VISION COVERAGE
				<input type="checkbox"/> I DO NOT HAVE OTHER VISION COVERAGE

Waive Coverage

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 conjunction with EyeMed Vision Care.