DELTA DENTAL®

Delta Dental of Wisconsin

DeltaVision® – Application

Wyssta Insurance Company, a wholly-owned subsidiary of Delta Dental of Wisconsin, is unable to accept this document with any changes, cross-outs, white-outs, etc. to the answers given unless the person signing the application initials all such changes.

In order to honor the requested effective date of coverage, **all materials** must be received by Wyssta no later than five business days prior to the requested effective date. Wyssta reserves the right to designate the effective date if materials are not received within this timeframe. **Please print clearly.**

ENROLLMENT CHECKLIST

- ☐ A completed employer application form
- ☐ A check for the first month's premium, and a completed ACH form *(if ACH is selected)*
- ☐ A copy of the sold proposal outlining benefits
- ☐ Completed enrollment forms *(Enrollment forms may not be required if eligibility reporting method is spreadsheet or electronic)*

INFORMATION IN THIS BOX IS REQUIRED

Total Number of Eligible Employees: _____
(Include completed waivers for those not enrolling)

Total Number of Employees Enrolling: _____

Requested Effective Date: _____

STEP 1 – EMPLOYER INFORMATION

Legal Business Name | DBA (If different)

Address | PO Box

City | State | Zip

Phone | Fax

Nature of Business | SIC code

Previous Vision Carrier

Benefit Contact Name | Benefit Contact Title

Benefit Contact Phone | Benefit Contact Email

Billing Contact Name | Billing Contact Title

Billing Contact Phone | Billing Contact Email

Payment Method: ☐ ACH *(See page 3)* ☐ Check *(A check from the customer for the first month's premium is required for both payment methods)*

Billing Delivery Method: ☐ Paper ☐ Email If email, specify email address _____

STEP 2 – PLAN DESIGN

Please choose a plan and enter the Quote number below.
Refer to your proposal to complete this section.

For questions on this application, contact your agent or call our Sales department at 800-236-3713 or email sales@deltadentalwi.com

Plan Information

Choose a DeltaVision® Plan:

- ☐ Comprehensive Plan
- ☐ Materials-Only Plan Allowance
- ☐ Nonstandard Plan

INFORMATION IN THIS BOX IS REQUIRED

Quote number: _____

(Note: Quote number can be found in the upper right corner of the proposal rate page)

Employer Contribution & Rates

	☐ Two-Tier		OR	☐ Three-Tier		
Employer Contribution	_____ % Employee	_____ % Family		_____ % Employee	_____ % Emp. / Dependent	_____ % Emp. / Two or More Dependents
Rates	$ _____ Employee	$ _____ Family		$ _____ Employee	$ _____ Emp. / Dependent	$ _____ Emp. / Two or More Dependents

OR

	☐ Four-Tier			
Employer Contribution	_____ % Employee	_____ % Emp / Spouse	_____ % Emp. / Child(ren)	_____ % Emp. / Spouse / Child(ren)
Rates	$ _____ Employee	$ _____ Emp / Spouse	$ _____ Emp. / Child(ren)	$ _____ Emp. / Spouse / Child(ren)

Employee Eligibility

Employees are eligible for coverage on *(select one)*:

- ☐ Date of hire *(no waiting period)*
- ☐ 1st of the month following the date of hire
- ☐ 1st of the month following _____ days after date of hire
- ☐ _____ days of employment after date of hire

Employee terms of eligibility:

- ☐ 30 hours minimum average hours worked per week
- ☐ Other *(specify)* _____

Termination date for employees:

☐ Date of termination ☐ End of month following termination

Dependents/students are covered to:

☐ Birthdate ☐ End of month following birthdate

Coverage for domestic partners:

☐ Yes ☐ No

Qualifying events effective date:

- ☐ Date of qualifying event
- ☐ 1st of the month following the date of the qualifying event

STEP 3 – AGENT **OR** CONSULTANT INFORMATION

Agent Name | Agency Name | Agency Fed. ID No.

Address | Email

Phone | NPN

Consultant Name | Firm Name

Phone | Agency Fed. ID No.

Address | Email

STEP 4 – ACH FINANCING AGREEMENT *(OPTIONAL)*

Automated clearinghouse (ACH) transfer of funds is a safe, easy, and effective way to ensure proper funding of the group's account. To set up an ACH transfer, please complete the information below. This information is only required for groups paying via ACH. Note: For fully-insured plans with ACH, a check for the first month's premium is required with the application and this ACH form.

Customer Contact Name | Customer Contact Phone

Customer Contact Email | Secondary Customer Contact Email

Depository Name | Depository Transit/WBA No.

Account Name | Account No. ☐ Savings or ☐ Checking

I (we) hereby authorize Delta Dental of Wisconsin, Inc., hereinafter called Company, to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my (our) account and the financial institution indicated above, herein called Depository, to debit and/or credit the same such account. This authority is to remain in full force and effect until Company has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Company and Depository a reasonable opportunity to act on it.

Name | Name

Signature | Date | Signature | Date

STEP 5 – EMPLOYER AGREEMENT

In making this application to Wyssta Insurance Company, Inc., a wholly-owned subsidiary of Delta Dental of Wisconsin, Inc. for group vision coverage under this program, the Group agrees and understands this application will become part of the Contract executed by an authorized officer of Wyssta. It is agreed that the coverage requested is subject to the approval of Wyssta and that no agent or representative has authority to make or modify this application for coverage. The Group hereby certifies that all of the above information is true and correct. The Group understands that coverage will not be effective until questions regarding eligibility for coverage have been satisfactorily resolved. The Group agrees to be bound by the terms of the Contract issued by Wyssta. Misrepresentations that the Group makes in information or data submitted to Wyssta with this application may affect Wyssta's obligation to the Group under the Contract or cause Wyssta to rescind the Contract.

Name | Title | Email

Signature | Date

Approval of coverage is contingent upon Underwriting acceptance.

Delta Dental of Wisconsin | Attention: Sales
2801 Hoover Rd. | PO Box 828 | Stevens Point, WI 54481-0828
Email: sales@deltadentalwi.com | Fax: 715-343-7623

DELTA DENTAL®

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