DELTA DENTAL

DeltaVision®
Coverage by Wellness 605, Inc.

Enrollment/Change Form

Effective date: ________________

720 N Euclid Ave, Pierre, SD 57501
800-627-3961 Fax 605-224-0909

Hire date: ____________________

Group name: ____ Group number: ______________________

Employee name: ____ SSN: ___________________

Mailing address: ____ Birth date: ____________________

City/State/Zip: ____ Gender: ___M ___F

Cell phone* ____________________Email:* _____________________________________

Marital status (we do not recognize common law marriage): Single ___ Married ___

Add or Drop	First Name	Last Name	Birth Date	Gender	Coverage Type
☐Add ☐Drop	Spouse				☐Dental ☐Vision

Cell phone* ______________________ Email* ____

Add or Drop	First Name	Last Name	Birth Date	Gender	Coverage Type
☐Add ☐Drop	Child				☐Dental ☐Vision

Cell phone* ______________________ Email* ____

Add or Drop	First Name	Last Name	Birth Date	Gender	Coverage Type
☐Add ☐Drop	Child				☐Dental ☐Vision

Cell phone* ______________________ Email* ____

Add or Drop	First Name	Last Name	Birth Date	Gender	Coverage Type
☐Add ☐Drop	Child				☐Dental ☐Vision

Cell phone* ______________________ Email* ____

Change in coverage

Marriage date: ____________________________________ Divorce date: ______________________________

Other (explain): __________________________________ Date of change: ____________________________

Signature: ____ Date: ___________________

DeltaVision is offered to you in partnership with EyeMed and underwritten by Wellness 605, Inc., a wholly owned company of Delta Dental of South Dakota. DeltaVision and Delta Dental are registered marks of Delta Dental Plans Association.

Delta Dental (DDSD) Coverage I accept the dental insurance provided by my employer and allow payroll deductions toward the cost of insurance (if any). I understand that I need to remain enrolled and cannot make a change in coverage until the next open enrollment period.

Wellness 605, Inc. Coverage I accept the vision insurance provided by my employer and allow payroll deductions toward the cost of insurance (if any). I understand that I need to remain enrolled and cannot make a change in coverage until the next open enrollment period.

Waiver of Coverage 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 future enrollment form will be subject to the terms and conditions of my employer's Policy. I also understand that DDSD and Wellness 605, Inc. reserve the right to reject the enrollment form.

* I agree to let DDSD and Wellness 605, Inc. use this information for surveys for people over 18. Email and text messages may not be secure.