WAICU
Wisconsin Association of Independent Colleges and Universities

Application for Individual Dental Insurance from
Delta Dental of Wisconsin
PLEASE TYPE OR PRINT IN BLACK INK
BE SURE APPLICATION IS COMPLETED IN FULL

DELTA DENTAL®

Delta Dental of Wisconsin
c/o WPS Health Insurance
P.O. Box 9
Madison, WI 53701-0009
Fax: 608-223-3693

Last Name	First Name	Middle Initial	Gender: M/F

Home Address (Mailing)	City	State	ZIP	Phone No. (with area code)

Email Address	Date of Birth	Marital Status: Single/Married

Reason for Application: ☐ New Enrollment ☐ Change of Dependent(s) ☐ Change in Enrollment (Single/Family Plan)

Are you covered under the short-term medical coverage offered through your college or university? ☐ Yes ☐ No

If you answer "no," you are not eligible for the dental plan. The dental plan is only available if you select the health plan offered by your college or university

Name of college you are currently attending: _____

PLEASE LIST ALL ELIGIBLE DEPENDENT(S) TO BE COVERED UNDER THIS POLICY

First Name	Last Name (If different from Applicant)	Date of Birth	Relationship to Applicant	Gender M/F

PRIOR COVERAGE. Were any of the above enrollees covered by a comprehensive dental plan within the past 60 days?

☐ Yes ☐ No If yes, with whom? _____ Policy # _____

If yes, please provide the names of those enrollees:

_____ _____

_____ _____

_____ _____

_____ _____

Delta Dental of Wisconsin will verify previous coverage of enrollees. Upon validation, waiting periods may be waived.

PAYMENT INSTRUCTIONS:

Please check the mode of payment you're requesting in either A or B below:

A. ☐ AUTOMATIC WITHDRAWAL. We electronically transfer your premium directly from your bank account at the frequency you request. (If you select this option, please complete the Automatic Withdrawal Payment Authorization Form.)

☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually

With this option, your first premium payment can be drafted from your bank account.

B. ☐ DIRECT BILL. We send a premium notice directly to your home at the frequency you request. You return payment to WPS by the premium due date.

☐ Semiannually ☐ Annually (with no billing fee)

Please complete the following information for payment by EFT (automatic withdrawal):

Name of Financial Institution _____

Financial Institution's City, State & ZIP Code _____

Type of Account (Choose one) ☐ Checking ☐ Savings Name on Account _____

Bank Routing Number _____ Bank Account Number _____

Please indicate the date in which you wish your premium payment withdrawn from your account:

☐ First day of the month ☐ 15th day of the month ☐ 20th day of the month

(Withdrawal occurs the month prior to the billing date. If you don't indicate a date of withdrawal, the withdrawal date shall be the 20th of each month.)

I hereby authorize WPS Health Insurance to initiate debit entries from my above bank account for my dental insurance premiums.

Signed: _____Date: _____

I understand that any EFT transaction that is dishonored by my financial institution intended for payment to WPS Health Insurance, may be assessed a $25.00 service charge by WPS Health Insurance.

In making this application to Delta Dental of Wisconsin, Inc., (DDWI), for dental coverage under this program, I agree and understand that this application will become part of the Policy and I agree to be bound by the terms of the Policy issued by DDWI. I further agree that the coverage requested is subject to the approval of DDWI and that no agent or representative has authority to make changes or modify this application for coverage. I hereby certify that all of the information contained in this application is true and correct to the best of my knowledge. I further understand that misrepresentation of submitted data may cause this application and subsequent Policy to be null and void.

By my submission of this application I attest that I am not eligible for dental coverage through Delta Dental of Wisconsin through my current employer. If at any time I become eligible for Delta Dental of Wisconsin group coverage through my employer, Delta Dental reserves the right to terminate this plan with thirty (30) days notice.

Your Policy will become effective on the first day of the month following approval of your application.

_____ _____

Applicant Signature Date

Coverage is contingent upon underwriting acceptance