

Plan Effective Date: _____

Currently have Delta Dental of Iowa dental coverage

Group Rate Structure: 2-tier 3-tier* or 4-tier*
(*3 or 4 tier rates available if 10 or more enrolled)

<input type="checkbox"/> Enhanced 10 / 10	<input type="checkbox"/> Enhanced 10 / 25	<input type="checkbox"/> Materials Only
<input type="checkbox"/> Preferred 10 / 10	<input type="checkbox"/> Preferred 10 / 25	<input type="checkbox"/> <u>Contributory Vision Plan</u>
<input type="checkbox"/> Standard 10 / 10	<input type="checkbox"/> Standard 10 / 25	<input type="checkbox"/> <u>Voluntary Vision Plan</u>

Employer Name _____ Phone (____) _____

Address _____
Street (PO Box) _____ City _____ State _____ Zip _____

Nature of Business _____ Years in Business _____ NAICS (SIC)# _____

Decision Maker Contact _____ Phone (____) _____
Name _____ Title _____

E-Mail Address _____ Fax # _____

Group Billing Contact _____ Phone (____) _____
Name _____ Title _____

E-Mail Address _____ Fax # _____

Billing Invoice Delivery: E-mail notification will be sent to above billing contact when monthly invoice is available to view.

ACH (authorization on 2nd page of group application) monthly check submission

New hires effective 1st of the month following date of hire 30 days 60 days 90 days or other _____

eligible employees _____ # employees enrolling with DeltaVision _____ # not enrolling _____

Employer Contribution (Contributory groups only): _____% of Single _____% of Total Premium

Previous Vision Carrier _____

EMPLOYER AGREEMENT

In making this application to Veratrus Benefit Solutions, Inc. for group vision coverage, I agree and understand this application will become part of the Contract executed by an authorized officer of Veratrus Benefit Solutions, Inc. It is agreed that the coverage requested is subject to the approval of Veratrus Benefit Solutions, Inc. and that no agent or representative has authority to make this application for coverage.

Misrepresentation of submitted information will cause this application and subsequent contract to be null and void.

Signed _____ Title _____

Name _____ Date _____

(Please Print or Type name of person signing application)

AGENT INFORMATION

Agent's Name _____ Phone (____) _____

Agency Name _____ E-mail _____

Agent's Statement: As the acting representative for this group, to the best of my knowledge and ability, I have complied with the underwriting rules as set forth by Veratrus Benefit Solutions, Inc.

Agent's Signature _____ Date _____

For Internal Use Only

Underwriting Information:
Group Number : _____
Category Number: _____
Master Number: _____
Underwriting Initials _____ Date: _____

Marketing Information:
Rep # _____ Brk. ID/Amt. _____
Agent _____ Consultant _____
Participation _____% Contribution _____%
Existing Delta Dental Group Number _____
Marketing Initials _____ Date: _____

***GROUP ACCOUNT WITHDRAWAL AUTHORIZATION** (*Premiums are withdrawn on the first working day of each month*)

As an officer having authority to withdraw corporate funds on behalf of _____, I hereby authorize Delta Dental of Iowa to initiate debit entries to the account at the financial institution indicated below. This authorization is for the purpose of paying Delta Dental for claims and administrative fees, and I understand that the amounts are subject to change based on claim volumes and eligibility changes.

Name of Financial Institution Branch (if applicable)

Address of Financial Institution (Street) City State Zip Code

Bank Routing Number Account Number

This authority is to remain in full force and effect until Delta Dental of Iowa receives written notification, from an officer of this group, of its termination in such time and manner as to allow Delta Dental and the designated financial institution reasonable opportunity to act on it.

I certify to the best of my knowledge that the banking information given is not that of a foreign banking institution (located outside of the United States).*

Signature and Title of Officer authorized to withdraw funds Date Signed

*If your banking institution is a foreign bank, please contact Delta Dental of Iowa for further instructions @ 515-261-5515

Group Enrollment Requirements

Contributory Vision Plan

Participation: A minimum of 50% of your group's total eligible employees must enroll. To be an eligible employer group, a minimum of 2 employees must enroll.

Contribution: Recommendation for employer contribution is 100% of the single rate or 50% of the total premium to insure participation requirements are met.

Voluntary Vision Plan

Participation: A minimum of 20% of your group's total eligible employees must enroll. To be an eligible employer group, a minimum of 2 employees must enroll.

Contribution: Employers contribute less than 50% of total premium. The employer administers the plan.

Enrolling a New Group

1. Complete **all** of the information on the **DeltaVision Group Application**.
2. Enrollment information is required for all full-time (or eligible) employees. Enrollment information is accepted via (a) electronic media (b) Excel reports using pre-determined format or (c) paper applications. Those employees wishing to waive coverage should be accounted for with the submission of enrollment information.
3. For vision only groups (no Delta Dental coverage), please provide a list of benefit eligible employees. Please exclude or indicate any employee that is not eligible to elect vision coverage.
4. You may send a check for the first month's premium, along with this completed group application, current wage & tax report and employee enrollment information to the address shown below or an invoice will be sent to you.
5. All enrollment materials should be sent to us at least 20 working days prior to the effective date of coverage to ensure timely delivery of enrolled member documents.

DeltaVision
Marketing Department
PO Box 9010
Johnston, IA 50131-9010
Fax #: 888-264-1433
Toll Free #: 1-877-423-3582 x4