

1 PLAN AND RATE INFORMATION

Plan Effective Date: _____ Currently have Delta Dental of Iowa dental coverage

Plan Options

Choose one option from each of the sections below.

Lens Copay:

- \$10
 \$25

Frame Allowance:

- \$130
 \$150
 \$200

Fit and Follow-Up Exam:

- Included
 Discounted

— OR —

Materials Only:

- Frame Allowance
 \$130
 \$150
 \$200

— OR —

Other: _____

Rate Options:

Rate Structure: 2-Tier 3-Tier 4-Tier

Contributory

Employer Contributions:
_____ % of Single _____ % of Total Premium

— OR —

Voluntary

2 GROUP INFORMATION

Company Name _____ Phone (____) _____

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

Industry _____ Years in Business _____ NAICS (SIC)# _____

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

Email Address _____ Fax # _____

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

Email Address _____ Fax # _____

Payment Options: ACH (authorization on 2nd page of application) **OR** Pay by Check

(Email notification will be sent to billing contact named above when monthly invoice is available to view.)

New Hire Effective 1st of the month following: Date of Hire 30 Days 60 Days Other _____

Number of Eligible Employees _____ Number of Employees Enrolling with DeltaVision _____

Number of Employees Not Enrolling _____ Number of Employees with other Coverage _____

Previous Vision Carrier _____

3 AGREEMENT AND SIGNATURE

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

Signed **X** _____ Title **X** _____

Printed Name **X** _____ Date **X** _____

4 PAYMENT INFORMATION

Group Account Withdrawal Authorization *(Premiums are withdrawn on the first business day of each month)*

Name of Financial Institution _____ Branch (if applicable) _____

Address of Financial Institution (Street, City, State, Zip) _____

Bank Routing Number _____ Account Number _____

As an officer having authority to withdraw corporate funds on behalf of _____, I hereby authorize Delta Dental of Iowa and the financial institution named to withdraw monthly premium payments from the checking or savings account that I selected. I further authorize Delta Dental of Iowa to initiate adjustment entries to this account when necessary.

I understand the first month's premium will be withdrawn from the listed account starting on the 1st business day of the month of the policy effective date, and thereafter will be deducted on the 1st business day of each month. This authorization is for the purpose of paying monthly premiums for group vision coverage. This authority to withdraw payments is to remain in full force and effect until Delta Dental of Iowa has received written notification from an officer of the above named organization of its withdrawal.

I understand in order to revoke my authorization provided or make changes to my payment information, an officer of the above named organization or I must contact Delta Dental of Iowa at TeamService@deltadentalia.com or send a written request to Delta Dental of Iowa P.O. Box 9010, Johnston, Iowa 50131-9010.

Delta Dental of Iowa and Vertrus Benefit Solutions, Inc. SHALL BEAR NO LIABILITY OR RESPONSIBILITY FOR ANY LOSSES OF ANY KIND THAT YOU MAY INCUR AS A RESULT OF AN ERRONEOUS STATEMENT, ANY DELAY IN THE ACTUAL DATE ON WHICH YOUR ACCOUNT IS DEBITED, OR YOUR FAILURE TO PROVIDE ACCURATE AND/OR VALID PAYMENT INFORMATION.

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).*

X _____ X _____
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 at 515-261-5515 for further instructions.

5 AGENT INFORMATION

Agent Name _____ Phone (____) _____

Agency Name _____ Email _____

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 X _____ Date X _____

ENROLLMENT REQUIREMENTS

	Participation	Contribution
Contributory	<ul style="list-style-type: none">• Minimum of 50% of total eligible employees must enroll.• To be an eligible group, a minimum of 2 employees must enroll.	<ul style="list-style-type: none">• Recommended employer contribution is 100% of single rate or 50% of the total premium.
Voluntary*	<ul style="list-style-type: none">• Minimum of 20% of total eligible employees must enroll.• To be an eligible group, a minimum of 2 employees must enroll.	<ul style="list-style-type: none">• Employer contributes less than 50% of total premium.

All enrollment materials **should be sent to Delta Dental at least 30 days prior to the effective date** of coverage to ensure delivery of identification cards and benefits documents by the effective date. The following employee enrollment forms must be completed and sent in with your group application:

1. Enrollment forms are **required for all eligible employees**. Employees waiving coverage must sign the waiver portion of the form. If enrollment information will be submitted via Excel spreadsheet, please contact Delta Dental of Iowa for the file format.
2. For vision only groups (group does not have dental coverage through Delta Dental), please provide a list of benefit eligible employees. Exclude or indicate any employee that is not eligible to elect vision coverage.

Materials should be sent to:



TeamReNEW@deltadentalia.com



DeltaVision
Team ReNEW
PO BOX 9010
Johnston, IA 50131-9010

*All voluntary plans require enrollment maintenance and payroll deduction by the employer.

Delta Dental of Iowa complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. To review our full non-discrimination notice, please go to www.deltadentalia.com/nondiscrimination.

DeltaVision is underwritten by Veratrus Benefit Solutions, Inc., a wholly-owned subsidiary of Delta Dental of Iowa.

Required Federal Notice-Nondiscrimination and Accessibility

Delta Dental of Iowa complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. To review our full nondiscrimination notice go to www.deltadentalia.com/nondiscrimination.

Delta Dental of Iowa provides free language services to people whose primary language is not English. In addition, Delta Dental provides free services for people with disabilities such as auxiliary aids, written communication in other formats such as large print, audio or other formats. If you need these services, call 1-877-983-3582, hearing impaired (TTY) call 1-888-287-7312.

Language Access Service

If you, or someone you're helping, has questions about Delta Dental of Iowa, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-877-983-3582.

Arabic –

إن كان لديك أو لدى شخص تساعدك أسئلة بخصوص Delta Dental of Iowa فلدليك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-983-3582.

Chinese – 如果您，或是您正在協助的對象，有關於 Delta Dental of Iowa 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請致電 1-877-983-3582

French – Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Delta Dental of Iowa, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-877-983-3582.

German – Falls Sie oder jemand, dem Sie helfen, Fragen zum Delta Dental of Iowa haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-983-3582 an.

Hindi – यदि आपके, या आप द्वारा सहायता किए जा रहे किसी व्यक्ति के Delta Dental of Iowa के बारे में प्रश्न हैं, तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। किसी दुभाषिण से बात करने के लिए 1-877-983-3582 पर कॉल करें।

Karen – မှတ်တမ်း ပုဂ္ဂလိကလူမှုဝန်ထမ်းများ၊ မှတ်တမ်း တင်သံကွက်တစ်ခုခုရှိသူများ၊ Delta Dental of Iowa နှင့် ဆက်သွယ်ရန် တောင်းဆိုလိုပါက အောက်ဖော်ပြပါ အချက်များကို အသိပြုရန် လိုအပ်ပါသည်။ လူမှုဝန်ထမ်းများနှင့် ဆက်သွယ်ရန်အတွက် ဖုန်းနံပါတ် 1-877-983-3582 တို့ကို ခေါ်ဆိုပါ။

Korean – 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Delta Dental of Iowa에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-983-3582로 전화하십시오.

Laotian – ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ ມີຄຳຖາມກ່ຽວກັບ Delta Dental of Iowa, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອໂອ້ນລັກບັນນາຍພາສາ, ໃຫ້ໂທຫາ 1-877-983-3582.

Pennsylvania Dutch: Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Delta Dental of Iowa, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch grieve, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-877-983-3582 uffruefe.

Russian – Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Delta Dental of Iowa, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-877-983-3582.

Serbo-Croatian – Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Delta Dental of Iowa, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-877-983-3582.

Spanish – Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Delta Dental of Iowa, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-983-3582.

Tagalog – Kung ikaw, o ang iyong tinutulongan, ay may mga katanungan tungkol sa Delta Dental of Iowa, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-983-3582.

Thai – หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Delta Dental of Iowa คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 1-877-983-3582

Vietnamese – Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Delta Dental of Iowa, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-983-3582.