

New Applicant
 Change of Coverage
 Name/Address Change

DeltaVision®

(Completed by Employer)

Group Number _____ **Effective Date** _____ / _____ / _____ **Department/EE Number** _____

1 POLICYHOLDER INFORMATION

Name (First, Middle Initial, Last) _____ **Social Security Number** _____
Mailing Address _____ **City** _____ **State** _____ **Zip** _____ **Status** Single Married **Hire Date** _____
 Other (specify) _____ / _____ / _____
Telephone (_____) _____ Home Cell Phone **Email Address** _____
Employer Name _____ **Employer Location** _____

2 ELIGIBLE MEMBERS ELECTING COVERAGE

List self & eligible members to be covered			Social Security Number	Birthdate	Sex	Coverage Selected	Full-Time College Student	Disabled Status	Other Dental Coverage
First Name	MI	Last (if different)							
Self				____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Dental <input type="checkbox"/> Vision		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No <input type="checkbox"/> Yes
Spouse				____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Dental <input type="checkbox"/> Vision		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eligible Child				____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eligible Child				____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eligible Child				____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No <input type="checkbox"/> Yes

Other Dental Coverage – if any person(s) on this application has other dental insurance please complete.

Policyholder _____
 Name of Other Carrier(s) _____ Policy Number _____ Effective Date _____ / _____ / _____ Contract Type Single Family

3 CHANGE OF COVERAGE

Please check events requiring Contract changes:

Marriage
 Death
 Divorce
 Birth/Adoption
 Drop Covered Person
 COBRA
 Terminating Benefits
 Other (explain) _____ Name of Affected Party _____ Date of Event _____ / _____ / _____

4 AGREEMENT AND CERTIFICATION

I have read and understand the Agreement and Certification and/or Waiver of Coverage language on the back of this application and acknowledge receipt of a fully completed copy of this application.

ACCEPTANCE/WAIVER OF COVERAGE

I accept the dental and/or vision coverage selected above.
 I waive dental coverage for my family members and/or myself. (Please indicate reason) _____
 I waive vision coverage for my family members and/or myself. (Please indicate reason) _____

X _____ / _____ / _____
 Employee Signature _____ Date _____

AGREEMENT AND CERTIFICATION

I certify I am legally authorized to apply for coverage for myself and/or for all other persons named in this application. I understand I am applying for coverage sponsored by my employer or Plan Sponsor offered by Delta Dental of Iowa ("Delta Dental") and/or Veratrus Benefit Solutions, Inc. ("VBS"). I authorize my employer, to deduct from my pay or collect from me in advance the premium therefore and remit such sums to Delta Dental on my behalf. This authorization is to remain in effect until I, or my employer or Plan Sponsor, notifies Delta Dental to the contrary. I understand coverage for the dental and/or vision policy applied for will not start until after this application and the monies for the first month's premium are deducted from my pay or paid to my employer, and are received and accepted by Delta Dental. I further understand that Delta Dental establishes the effective date of the policy. I also understand the amounts are subject to change at least annually and my employer or Plan Sponsor will furnish written notice of such changes to me.

I certify that after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct, to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that Delta Dental will rely upon the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or have concealed any material fact, Delta Dental will be entitled to declare the dental and/or vision policy applied for void and refuse allowance of benefits to any person thereunder.

I authorize any health care provider to release medical records to Delta Dental and VBS when reasonably related to the dental and/or vision coverage for which I have applied for. If any law or regulation requires additional authorization for release of dental and/or vision records, I will give this authorization.

WAIVER OF COVERAGE

I understand if I decide not to apply for coverage, or if I apply only for myself even though coverage is available for eligible members of my family, any subsequent application will be subject to the applicable terms and conditions of the Group Insurance Policy to provide dental and/or vision benefits, which may require additional limitations and waiting periods. I also understand Delta Dental reserves the right to reject such an application.

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 non-discrimination notice, please go to www.deltadentalia.com/nondiscrimination.

Required Federal Notice-Nondiscrimination and Accessibility

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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 (TYY) 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 ပုဂ္ဂလိကလူမှုဝန်ထမ်း၊ မှတ်တမ်း တင်သံကွပ်ကဲရေးဝန်ထမ်း၊ Delta Dental of Iowa နှင့် မှတ်တမ်း တင်ခွဲတင်ယာလ်နကဒီးနှိုက်တင်မေးခွဲတင် တင်တင်ကွပ်ကဲရေး နှင့် တင်တင် နေရာ တင်တင်ကွပ်ကဲရေး နှင့် တင်တင် လာနက် ကတင်တင်ဒီး ပုဂ္ဂလိကလူမှုဝန်ထမ်း၊ ကိ: 1-877-983-3582 တင်တင်။

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. ເພື່ອໂອ້ນລັກບັນຍາຍພາສາ, ໃຫ້ໂທຫາ 1-877-983-3582.

Pennsylvania Dutch: Wann du hoscht en Froog, odder ebber, wu du helpscht, 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 uffrufe.

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.