

EMPLOYER INFORMATION

| | | | | | | | |
|--|-----------------|------|-------|-----|-------------------|------|--|
| Company Name | | | | | Phone () | | |
| Address | | | | | | | |
| | Street (PO Box) | City | State | Zip | County | | |
| Industry | | | | | Years in Business | | |
| NAICS # | | | SIC # | | | FEIN | |
| Decision Maker Contact | | | | | Phone () | | |
| | Name | | | | Title | | |
| Email Address | | | | | Fax # | | |
| Billing Contact | | | | | Phone () | | |
| | Name | | | | Title | | |
| Email Address | | | | | Fax # | | |
| (Email notification will be sent to billing contact named above when monthly invoice is available to view.) | | | | | | | |
| Eligibility Contact | | | | | Phone () | | |
| | Name | | | | Title | | |
| Email Address | | | | | Fax # | | |

PRODUCT SELECTION**Dental**

- ☐ Add
☐ Decline
☐ Already Have
Delta Dental

Vision

- ☐ Add
☐ Decline
☐ Already Have
DeltaVision®

Legal

- ☐ Add
☐ Decline
☐ Already Have Legal
with Delta Dental

Life &/or Disability

- ☐ Add
☐ Decline
☐ Already Have
DeltaLife™

If you select "Add" for any of the products above, please complete the product form in the following pages.

BILLING & ADMINISTRATION

New hire eligibility: ☐ 1st of month following days ☐ Date of hire
☐ 1st of month following date of hire ☐ Other:

Coverage for Terminated employees/dependents ends: ☐ Last Day of Month **OR** ☐ Last Day Worked

Current Medical Carrier Previous Dental Carrier

Previous Vision Carrier Previous Legal Carrier

Previous Life & Disability Carrier

PAYMENT INFORMATION

Choose one of the following options to pay premiums. Please note, credit card payments will include a surcharge. Debit card payments are not accepted.

☐ **Account Withdrawal:**

Name of Financial Institution Branch (If applicable)

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

Bank Routing Number Account Number

☐ **Credit Card:**

Name as it appears on the card

Card number

Expiration date (MM/YYYY) CVV code (3- or 4-digit code on the front or back of your card)

Card type:

- ☐ VISA ☐ Mastercard
☐ Discover ☐ American Express

☐ **Check**

PAYMENT INFORMATION (Continued)

As an officer with authority to charge a credit card or withdraw corporate funds on behalf of _____, I hereby authorize Delta Dental of Iowa and the financial institution named to charge a credit card or 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.

Self-funded Groups (Dental only)

I understand payments will be charged or withdrawn from the listed account based on the option selected on our proposal. This authorization is for the purpose of paying claims and administration fees for dental benefits.

Fully Insured Groups

I understand the first month's premium will be charged or withdrawn from the listed account starting on the 1st business day of the month of the policy effective date, and thereafter will be charged or deducted on the 1st business day of each month. This authorization is for the purpose of paying monthly premiums for dental benefits.

This authority to charge a credit card or withdraw premium/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 Veratus 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 _____**Signature and Title of Officer Authorized to Pay Premiums****X** _____**Date Signed**

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

AGREEMENT AND SIGNATURE**Employer Agreement**

In making this application to Delta Dental of Iowa for group coverage, I agree and understand this application will become part of the Contract executed by an authorized officer of Delta Dental of Iowa. It is agreed that the coverage requested is subject to the approval of Delta Dental of Iowa and that no agent or representative has authority to make this application for coverage. Misrepresentation of submitted information will cause this application and subsequent contracts to be null and void.

Signed **X** _____**Title** **X** _____**Printed Name** **X** _____**Date** **X** _____**AGENT INFORMATION**

Agent Name _____

NPN Insurance License _____

Agency Name _____

Phone (____) _____

Email _____

Include this group in annual bonus payment program? ☐ Yes ☐ No

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 Delta Dental of Iowa.

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, please go to www.deltadentalia.com/nondiscrimination.

Please complete the product forms on the following pages for any products you selected "Add" on the previous page.

Only complete this page if adding the Prestige Plan.

BENEFIT AND RATE INFORMATION

Plan Effective Date / **1** / Renewal Date / **1** /
Corrective Orthodontia: ☐ Yes ☐ No Rate Options: ☐ Contributory ☐ Voluntary
Employer Contribution (if you select Contributory): Number of Eligible Employees:
 % of Employee Enrolling with Delta Dental:
 % of Family
 % of Total Premium Contribution

AGREEMENT AND SIGNATURE**Employer Agreement**

In making this application to Delta Dental of Iowa for group dental coverage, I agree and understand this application will become part of the Contract executed by an authorized officer of Delta Dental of Iowa. It is agreed that the coverage requested is subject to the approval of Delta Dental of Iowa and that no agent or representative has authority to make this application for coverage. Misrepresentation of submitted information will cause this application and subsequent contracts to be null and void.

Signed **X** Title **X**
Printed Name **X** Date **X**

AGENT INFORMATION

Agent Name NPN Insurance License 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 Delta Dental of Iowa.*

Agent's Signature **X** Date **X**

ENROLLMENT REQUIREMENTS

All enrollment materials **should be sent to Delta Dental of Iowa at least 30 days prior to the effective date** of coverage to ensure delivery of identification cards and information by the effective date. Enrollment forms are **only required for employees enrolling in coverage**. Employees waiving coverage do not need to do anything.

Materials should be sent to: **1** TeamReNEW@deltadentalia.com

2 Delta Dental of Iowa, Team ReNEW,
PO BOX 9010, Johnston, IA 50131-9010

Only complete this page if adding vision coverage.

BENEFIT AND RATE INFORMATION

Plan Effective Date / **1** / Renewal Date / **1** /

☐ Currently have Delta Dental of Iowa dental coverage

Please be sure to include signed quote exhibit for requested coverage along with current benefit certificate.

Number of Eligible Employees: Enrolling with DeltaVision:

COBRA

COBRA billed to: ☐ Group ☐ Individual

If bill to individual please provide COBRA rates: ☐ Single ☐ Family ☐ Emp/Spouse ☐ Emp/Child(ren)

Name and email of COBRA administrator:

AGREEMENT AND SIGNATURE**Employer Agreement**

In making this application to Veratus 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 Veratus Benefit Solutions, Inc. It is agreed that the coverage requested is subject to the approval of Veratus Benefit Solutions, Inc. and that no agent or representative has authority to bind coverage. Misrepresentation of submitted information will cause this application and subsequent contracts to be null and void.

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

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

AGENT INFORMATION

Agent Name NPN Insurance License

Agency Name Phone ()

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 Delta Dental of Iowa.

Agent's Signature **X** Date **X**

ENROLLMENT REQUIREMENTS

All enrollment materials **should be sent to Delta Dental of Iowa at least 30 days prior to the effective date** of coverage to ensure delivery of identification cards and information by the effective date. Enrollment forms are **only required for employees enrolling in coverage**. Employees waiving coverage do not need to do anything.

Materials should be sent to:

1

TeamReNEW@deltadentalia.com

2

Delta Dental of Iowa
Team ReNEW
PO BOX 9010
Johnston, IA 50131-9010

DeltaVision is underwritten by Veratus Benefit Solutions, Inc., a wholly-owned subsidiary of Delta Dental of Iowa, utilizing the EyeMed Vision Care Insight network.

Only complete this page if adding legal coverage.

PLAN INFORMATION

Plan Effective Date: / /
Month Day Year

Plan Choice:

☐ UltimateAdvisor® ☐ UltimateAdvisor Plus™

AGREEMENT AND SIGNATURE

Employer Agreement

In making this application to Delta Dental of Iowa for group legal coverage, I agree and understand this application will become part of the Contract executed by an authorized officer of Delta Dental of Iowa. It is agreed that the coverage requested is subject to the approval of Delta Dental of Iowa and that no agent or representative has authority to make this application for coverage. Misrepresentation of submitted information will cause this application and subsequent contracts to be null and void.

Signed Title
Printed Name Date

AGENT INFORMATION

Agent Name NPN Insurance License 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 Delta Dental of Iowa.

Agent's Signature Date

ENROLLMENT REQUIREMENTS

All enrollment materials **should be sent to Delta Dental of Iowa at least 30 days prior to the effective date** of coverage to ensure delivery of identification cards and information by the effective date. Enrollment forms are **only required for employees enrolling in coverage**. Employees waiving coverage do not need to do anything.

Materials should be sent to:

1

TeamReNEW@deltadentalia.com

2

Delta Dental of Iowa
Team ReNEW
PO BOX 9010
Johnston, IA 50131-9010

The Identity Theft Insurance is underwritten by American Bankers Insurance Company of Florida. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions. Please see the identity theft plan summary for details.

Limitations and exclusions apply. Depending on a state's regulations, ARAG's legal insurance plan may be considered an insurance product or a service product, insurance products are underwritten by ARAG Insurance Company of Des Moines, Iowa. Service products are provided by ARAG Services, LLC. This material is for illustrative purposes only and is not a contract. For terms, benefits or exclusions, call our toll-free number.

The coverage is underwritten by ARAG Insurance Company of Des Moines, Iowa.

Life & Disability Form

Only complete this page if adding life and/or disability coverage.

PLAN INFORMATION

Plan Effective Date: / **1** /
Month Day Year

Life Insurance

☐ Life Insurance

Select one:

☐ \$10,000☐ \$25,000☐ \$50,000

--OR--

☐ _____
Proposal Number☐ Voluntary Life Insurance☐ _____
Proposal Number☐ Dependent Voluntary
Life Insurance☐ _____
Proposal Number

Disability Insurance

☐ Short-Term Disability, 60% up to \$1,500 for 13 weeks

Select one:

☐ Employer Paid☐ Voluntary

--OR--

☐ _____
Proposal Number

Select one:

☐ 7 Day Elimination☐ 14 Day Elimination☐ Long-Term Disability, 60% up to \$6,000 to SSNRA

Select one:

☐ Employer Paid☐ Voluntary

--OR--

☐ _____
Proposal Number

Select one:

☐ 90 Day Elimination☐ 180 Day Elimination☐ Lump Sum Disability

Select one:

☐ Employer Paid☐ Voluntary

--OR--

☐ _____
Proposal Number

Select one:

☐ \$25,000☐ \$50,000

Select one:

☐ 90 Day Elimination☐ 180 Day Elimination

AGREEMENT AND SIGNATURE

Employer Agreement

In making this application to Delta Dental of Iowa for group coverage, I agree and understand this application will become part of the Contract executed by an authorized officer of Delta Dental of Iowa. It is agreed that the coverage requested is subject to the approval of Delta Dental of Iowa and that no agent or representative has authority to make this application for coverage. Misrepresentation of submitted information will cause this application and subsequent contracts to be null and void.

Signed **X** _____ Title **X** _____Printed Name **X** _____ Date **X** _____

AGENT INFORMATION

Agent Name _____ NPN Insurance License _____ 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 Delta Dental of Iowa.

Agent's Signature **X** _____ Date **X** _____

ENROLLMENT REQUIREMENTS

All enrollment materials **should be sent to Delta Dental of Iowa at least 30 days prior to the effective date** of coverage to ensure payroll deductions are communicated timely. A census file with employee enrollments and salary information (if applicable) will also need to be submitted to Delta Dental. Once received you will be sent a OneAmerica® application for electing and binding coverage.

Materials should be sent to: **1** TeamReNEW@deltadentalia.com**2** Delta Dental of Iowa
Team ReNEW
PO BOX 9010
Johnston, IA 50131-9010