DELTA DENTAL®

Small Business Application

Email: TeamReNEW@deltadentalia.com
Customer Service: 1-877-423-3582
Fax: 1-888-337-5157

EMPLOYER INFORMATION

Company Name _____ Phone (____) _____

Address _____
Street (PO Box) City State Zip County

Industry _____ Years in Business _____

NAICS # _____ SIC # _____ Tax ID # _____

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.)

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 Effective 1st of the month following: ☐ Date of Hire ☐ 30 Days ☐ 60 Days

Number of Eligible Employees _____ Number of Employees Enrolling with Delta Dental _____

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 or Online:** *(If you are paying by check or online, you do not need to complete this section.)*

DELTA DENTAL®

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.

I understand the first month's premium will be charged to the credit card or 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 Delta Dental of Iowa Insurance. This authority to charge the credit card or 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 Veratrus 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 Pay Premiums | Date Signed

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 _____

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.deltadentialia.com/nondiscrimination.

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

DELTA DENTAL®

Dental Application

Only complete this page if adding dental coverage.

BENEFIT AND RATE INFORMATION

Plan Options

Select **ONE** plan option below. Be sure to select additional details if requested, available for that plan option.

☐ 1. **Employer Choice Plan**

If you select an Employer Choice Plan, choose one option from each of the sections below.

Provider Network:
- ☐ PPO Plus Premier™
- ☐ Premier®

Plan Choice:
- ☐ Plan A Prime
- ☐ Plan C Prime
- ☐ Plan B Prime
- ☐ Plan B Plus*

*Plan B Plus includes the Affordable Care Act pediatric Essential Health Benefits.

Corrective Orthodontia:
☐ Yes ☐ No
If you selected Plan B Prime, please select one lifetime max:
☐ $1,500 ☐ $2,500

Healthy Smiles Program:
☐ Yes ☐ No
Adding this program will provide eligible employees and their covered spouse with a free electric toothbrush and replacement heads.

☐ 2. **Prestige Plan** — **Corrective Orthodontia:** ☐ Yes ☐ No

☐ 3. **Employee Choice Plans** – Delta Dental PPO Plus Premier™
Employee chooses from available plan options.

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

Rate Options

If you select an Employer Choice Plan, choose one option from each of the sections below.

If you select the Prestige Plan, only 4-Tier rates are available.

☐ Contributory
Rate Structure: ☐ Per Person ☐ 4-Tier
Employer Contributions:
_____% of Employee
_____% of Spouse and/or Dependents **OR**
_____% of Total Premium Contribution **OR**
Total Defined Contribution $ _____
Payroll Deduction Frequency _____
*Any amount of employer contribution is considered to be Contributory.

— OR —

☐ Voluntary
Rate Structure: ☐ Per Person ☐ 4-Tier

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 benefit certificates by the effective date. The following employee enrollment forms must be completed and sent in with your group application:

1. *Employer Choice Plans* – 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. *Employee Choice Plans* – 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

DELTA DENTAL®

DeltaVision®

Vision Application

Only complete this page if adding vision coverage.

BENEFIT AND RATE INFORMATION

Plan Effective Date: ____ / 1 / ____ (Month / Day / Year)

☐ Currently have Delta Dental of Iowa dental coverage

Plan Options

Select **ONE** plan option below. Be sure to select additional details if requested.

☐ **1. Standard Plan:** Please choose one option from each section below to customize your plan.

Lens Copay:	Frame Allowance:	Fit and Follow-Up Exam:
☐ $10	☐ $130	☐ Included
☐ $25	☐ $150	☐ Discounted
	☐ $200	

☐ **2. One & Sun™ Plan:** With this plan you will have a $10 lens copay, $150 frame allowance and Discounted Fit and Follow-Up Exams.

☐ **3. Materials Only Plan:** Please select a contact lens/frame allowance option below.

☐ $130 ☐ $150 ☐ $200

Rate Options

☐ Contributory

Employer Contributions:

_____% of Single _____% of Total Premium

With contributory plans the employer contributes any amount towards the premium. The recommended employer contribution is 100% of the single rate or 50% of the total premium.

— OR —

☐ Voluntary

With voluntary plans the employer does not contribute any amount towards the premium. All voluntary plans require enrollment maintenance and payroll deduction by the employer.

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 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 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 who is not eligible to elect vision coverage.

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 Veratrus Benefit Solutions, Inc., a wholly-owned subsidiary of Delta Dental of Iowa, utilizing the EyeMed Vision Care Insight network.

DELTA DENTAL®

Legal Application

Only complete this page if adding legal coverage.

PLAN INFORMATION

Plan Effective Date: ____ / 1 / ____
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 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 benefits 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.

DELTA DENTAL®

DeltaLife™

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:	**Select one:**
☐ Employer Paid	☐ 7 Day Elimination
☐ Voluntary	☐ 14 Day Elimination

--OR--

☐ _____
Proposal Number

☐ Long-Term Disability, 60% up to $6,000 to SSNRA

Select one:	**Select one:**
☐ Employer Paid	☐ 90 Day Elimination
☐ Voluntary	☐ 180 Day Elimination

--OR--

☐ _____
Proposal Number

☐ Lump Sum Disability

Select one:	**Select one:**	**Select one:**
☐ Employer Paid	☐ $25,000	☐ 90 Day Elimination
☐ Voluntary	☐ $50,000	☐ 180 Day Elimination

--OR--

☐ _____
Proposal Number

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 _____

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