DELTA DENTAL®

Vision Enrollment/Change Form

☐ New Applicant ☐ Change of Coverage ☐ Name/Address Change

DeltaVision®

(Completed by Employer)

Group Number 43023 **Effective Date** __/__/__ **Department/EE Number**

1 POLICYHOLDER INFORMATION

Name (First, Middle Initial, Last) **Social Security Number**

Mailing Address **City** **State** **Zip** **Status** ☐ Single ☐ Married ☐ Other (specify) **Hire Date** __/__/__

Telephone (___) ☐ Home ☐ Cell Phone **Email Address**

Employer Name **Employer Location**

2 ELIGIBLE MEMBERS ELECTING COVERAGE

List self & eligible members to be covered First Name MI Last (if different)	Social Security Number	Birthdate	Sex	Full-Time College Student	Disabled Status
Self		__/__/__	☐ M ■ F		☐ Yes ■ No
Spouse		__/__/__	☐ M ☐ F		☐ Yes ☐ No
Eligible Child		__/__/__	☐ M ☐ F	☐ Yes ☐ No School Name:	☐ Yes ☐ No
Eligible Child		__/__/__	☐ M ☐ F	☐ Yes ☐ No School Name:	☐ Yes ☐ No
Eligible Child		__/__/__	☐ M ☐ F	☐ Yes ☐ No School Name:	☐ Yes ☐ No

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 vision coverage selected above.

☐ I waive vision coverage for my family members and/or myself. (Please indicate reason)

X _____ __/__/__

Employee Signature Date

TeamService@deltadentalia.com • www.deltadentalia.com • **Fax:** 1-888-558-9212 • **Phone:** 1-877-423-3582

(Over, please)

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 Veratrus Benefit Solutions, Inc. ("VBS") , a wholly owned subsidiary of Delta Dental of Iowa ("Delta Dental"). I authorize my employer to deduct from my pay or collect from me in advance the premium and remit such sums to VBS 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 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 VBS 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, VBS will be entitled to declare the vision policy applied for void and refuse allowance of benefits to any person hereunder.

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

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

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