STATE OF IOWA EMPLOYEES

ENROLLMENT/CHANGE FORM

Please print and complete all sections. See instructions below.

Offered through Veratrus Benefit Solutions, Inc., a wholly-owned subsidiary of Delta Dental of Iowa

FOR BEST RESULTS: Download this pdf and complete by using Adobe Acrobat Reader.

EMPLOYER INFORMATION:

Group Number 9713249 | State of Iowa Employees | State of Iowa Voluntary Vision Plan

Effective Date ____________________ Other ____________________

Dept # ____________________

EMPLOYEE INFORMATION: A: Add (enroll) T: Terminate C: Change (change of name, address or phone)

○ A ○ T ○ C | Sex ○ M ○ F

Last Name (Employee or subscriber) ____________ First Name ____________ M.I. ______

Date of Birth ____________ Date of Hire ____________

Social Security # ____________ Home Phone ____________

Home Street Address ____________ City ____________ State ______ Zip ______

FAMILY INFORMATION: (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name)

○ A ○ T ○ C | Sex ○ M ○ F

Last Name (spouse) ____________ First Name ____________ M.I. ______

Date of Birth ____________ (Month/Day/Year)

○ A ○ T ○ C | Sex ○ M ○ F

Last Name (dependent) ____________ First Name ____________ M.I. ______

Date of Birth ____________ (Month/Day/Year)

○ A ○ T ○ C | Sex ○ M ○ F

Last Name (dependent) ____________ First Name ____________ M.I. ______

Date of Birth ____________ (Month/Day/Year)

○ A ○ T ○ C | Sex ○ M ○ F

Last Name (dependent) ____________ First Name ____________ M.I. ______

Date of Birth ____________ (Month/Day/Year)

○ A ○ T ○ C | Sex ○ M ○ F

Last Name (dependent) ____________ First Name ____________ M.I. ______

Date of Birth ____________ (Month/Day/Year)

○ A ○ T ○ C | Sex ○ M ○ F

Last Name (dependent) ____________ First Name ____________ M.I. ______

Date of Birth ____________ (Month/Day/Year)

Employee Signature ____________________ Date ____________

INSTRUCTIONS:

Employer name: Legal name of the employer.

Group Number: Provided by carrier.

Effective date: Date set by employer in accordance with EyeMed proposal. Employer also sets effective date for new adds during contract period.

Family Information: List only eligible family members who are enrolling. Dependent eligibility is the same as employer's health plan.

(A) Add: Open (group) enrollment or new (individual) enrollment during the contract period.

(T) Terminate: To terminate enrollment.

(C) Change: A change of name, employee address or employee phone.

YOUR AUTHORIZATION:

I authorize vision plan payroll deduction for:

Per Employee only per month	$8.82
Per Employee + spouse per month	$16.44
Per Employee + child(ren) per month	$16.90
Per Employee + family per month	$24.14

SEND FORM TO:

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