DELTA DENTAL®

DeltaVision®

Large Employer Group Vision Application

1 EMPLOYER INFORMATION

Company Name _____ Phone (_____) _____

Address _____
Street (PO Box) City State Zip

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.)

2 BENEFIT INFORMATION

Plan Effective Date _____/_____/_____ Renewal Date_____/_____/_____

☐ 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: ____ With Other Vision: ____ Not Enrolling: ____

3 COBRA

COBRA billed to: ☐ Group ☐ Individual

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

Name and email of COBRA administrator: _____

4 BILLING & ADMINISTRATION

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

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

Payment Method: ☐ ACH (complete Group Account Withdrawal Authorization)
☐ Check

5 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 contract to be null and void.**

Signed X _____ **Title X** _____

Printed Name X _____ **Date X** _____

(Over, please)

5 AGREEMENT AND SIGNATURE (Continued)

Group Account Withdrawal Authorization *(Premiums are withdrawn on the first business day of each month)*

Name of Financial Institution _____ Branch (if applicable) _____

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

Bank Routing Number _____ Account Number _____

As an officer having authority to withdraw corporate funds on behalf of _____, I hereby authorize Delta Dental of Iowa and the financial institution named to 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 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 group vision coverage. This authority to 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.

I UNDERSTAND Delta Dental of Iowa and Veratrus Benefit Solutions, Inc. SHALL BEAR NO LIABILITY OR RESPONSIBILITY FOR ANY LOSSES OF ANY KIND THAT I MAY INCUR AS A RESULT OF AN ERRONEOUS STATEMENT, ANY DELAY IN THE ACTUAL DATE ON WHICH MY ACCOUNT IS DEBITED, OR MY 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 withdraw funds **Date Signed**

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

6 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 Veratrus Benefit Solutions, Inc.

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

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