DELTA DENTAL®

DeltaVision®

Vision Group Application

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

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.)

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 _____

Previous Vision Carrier _____

2 BENEFIT AND RATE INFORMATION

Plan Effective Date: _____ ☐ 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 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.

3 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)

4 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 _____

Card type:
☐ VISA ☐ Mastercard
☐ Discover ☐ American Express

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

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

As an officer having 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 group vision coverage. 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.

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 Pay Premiums — Date Signed

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

5 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 _____

ENROLLMENT REQUIREMENTS

All enrollment materials **should be sent to Delta Dental 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.

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