DELTA DENTAL®

DeltaVision® Group Application

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

Plan Effective Date: _____

☐ **Currently have Delta Dental of Iowa dental coverage**

Group Rate Structure: ☐ **2-tier** ☐ **3-tier*** **or** ☐**4-tier***

(*3 or 4 tier rates available if 10 or more enrolled)

☐ **Enhanced 10 / 10** ☐ **Enhanced 10 / 25** ☐ **Materials Only** ☐ **Preferred 10 / 10** ☐ **Preferred 10 / 25** ☐ **Standard 10 / 10** ☐ **Standard 10 / 25**	☐ **Contributory Vision Plan** ☐ **Voluntary Vision Plan**

Employer Name _____Phone (_____)_____

Address _____
Street (PO Box) City State Zip

Nature of Business _____Years in Business _____ NAICS (SIC)# _____

Decision Maker Contact _____Phone (_____)_____
Name Title

E-Mail Address_____ Fax # _____

Group Billing Contact _____ Phone (_____)_____
Name Title

E-Mail Address _____ Fax # _____

Billing Invoice Delivery: E-mail notification will be sent to above billing contact when monthly invoice is available to view.

☐**ACH (authorization on 2nd page of group application)** ☐**monthly check submission**

New hires effective 1st of the month following ☐ date of hire ☐30 days ☐ 60 days ☐ 90 days or ☐other _____

 # eligible employees _____ # employees enrolling with DeltaVision _____ # not enrolling _____

Employer Contribution (Contributory groups only): _____% of Single _____% of Total Premium

Previous Vision Carrier _____

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 make this application for coverage.

Misrepresentation of submitted information will cause this application and subsequent contract to be null and void.

Signed _____ Title _____

Name _____ Date _____
(Please Print or Type name of person signing application)

AGENT INFORMATION

Agent's Name _____ Phone (_____)_____

Agency Name_____E-mail_____

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 _____ Date _____

For Internal Use Only

Underwriting Information:
Group Number : _____
Category Number: _____
Master Number: _____
Underwriting Initials _____ Date: _____

Marketing Information:
Rep # _____ Brk. ID/Amt. _____
Agent _____ Consultant _____
Participation _____% Contribution _____%

Existing Delta Dental Group Number_____
Marketing Initials _____ Date: _____

(See Reverse Side)

*GROUP ACCOUNT WITHDRAWAL AUTHORIZATION *(Premiums are withdrawn on the first working day of each month)*

As an officer having authority to withdraw corporate funds on behalf of _____, I hereby authorize Delta Dental of Iowa to initiate debit entries to the account at the financial institution indicated below. This authorization is for the purpose of paying Delta Dental for claims and administrative fees, and I understand that the amounts are subject to change based on claim volumes and eligibility changes.

_____ _____
Name of Financial Institution Branch (if applicable)

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

_____ _____
Bank Routing Number Account Number

This authority is to remain in full force and effect until Delta Dental of Iowa receives written notification, from an officer of this group, of its termination in such time and manner as to allow Delta Dental and the designated financial institution reasonable opportunity to act on it.

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).*

_____ _____
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 for further instructions @ 515-261-5515

Group Enrollment Requirements

Contributory Vision Plan

Participation: A minimum of 50% of your group's total eligible employees must enroll. To be an eligible employer group, a minimum of 2 employees must enroll.

Contribution: Recommendation for employer contribution is 100% of the single rate or 50% of the total premium to insure participation requirements are met.

Voluntary Vision Plan

Participation: A minimum of 20% of your group's total eligible employees must enroll. To be an eligible employer group, a minimum of 2 employees must enroll.

Contribution: Employers contribute less than 50% of total premium. The employer administers the plan.

Enrolling a New Group

1. Complete **all** of the information on the **DeltaVision Group Application.**
2. Enrollment information is required for all full-time (or eligible) employees. Enrollment information is accepted via (a) electronic media (b) Excel reports using pre-determined format or (c) paper applications. Those employees wishing to waive coverage should be accounted for with the submission of enrollment information.
3. Provide a copy of the employer's most recent State of Iowa Wage & Tax Report, Form 65-5300.
4. You may send a check for the first month's premium, along with this completed group application, current wage & tax report and employee enrollment information to the address shown below or an invoice will be sent to you.
5. All enrollment materials should be sent to us at least 20 working days prior to the effective date of coverage to ensure timely delivery of enrolled member documents.

DeltaVision
Marketing Department
PO Box 9010
Johnston, IA 50131-9010

Fax #: 888-264-1433
Toll Free #: 1-877-423-3582 x4