**DELTA DENTAL**®

# Association Application

## ASSOCIATION INFORMATION

Association Name ______ Group # ______

## EMPLOYER INFORMATION

Company Name ______ Phone ( ) ______

Address ______
Street (PO Box) City State Zip County

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.)**

Eligibility Contact ______ Phone ( ) ______
Name Title

Email Address ______ Fax # ______

## PRODUCT SELECTION

**Dental**
- ☐ Add
- ☐ Decline
- ☐ Already Have Delta Dental

**Vision**
- ☐ Add
- ☐ Decline
- ☐ Already Have DeltaVision®

**Legal**
- ☐ Add
- ☐ Decline
- ☐ Already Have Legal with Delta Dental

**Life &/or Disability**
- ☐ Add
- ☐ Decline
- ☐ Already Have DeltaLife™

If you select "Add" for any of the products above, please complete the product form in the following pages.

## BILLING & ADMINISTRATION

New hire eligibility: ☐ 1st of month following ______ days ☐ Date of hire
☐ 1st of month following date of hire ☐ Other: ______

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

Current Medical Carrier ______ Previous Dental Carrier ______

Previous Vision Carrier ______ Previous Legal Carrier ______

Previous Life & Disability Carrier ______

## 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 ______

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

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

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## PAYMENT INFORMATION (Continued)

As an officer with 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.

Self-funded Groups (Dental only)
I understand payments will be charged or withdrawn from the listed account based on the option selected on our proposal. This authorization is for the purpose of paying claims and administration fees for dental benefits.

Fully Insured Groups
I understand the first month's premium will be charged or withdrawn from the listed account starting on the 1st business day of the month of the policy effective date, and thereafter will be charged or deducted on the 1st business day of each month. This authorization is for the purpose of paying monthly premiums for dental benefits.

This authority to charge a credit card or withdraw premium/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.

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

## AGREEMENT AND SIGNATURE

### Employer Agreement

In making this application to Delta Dental of Iowa for group coverage, I agree and understand this application will become part of the Contract executed by an authorized officer of Delta Dental of Iowa. It is agreed that the coverage requested is subject to the approval of Delta Dental of Iowa and that no agent or representative has authority to make this application for coverage. Misrepresentation of submitted information will cause this application and subsequent contracts to be null and void.

**Signed** X ______________________ **Title** X ______________

**Printed Name** X ______________________ **Date** X ______________

## AGENT INFORMATION

Agent Name ______________________ NPN Insurance License ______________

Agency Name ______________________ Phone ( ______ ) ______________

Email ______________________

Include this group in annual bonus payment program? ☐ Yes ☐ No

***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 Delta Dental of Iowa.***

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 nondiscrimination notice, please go to www.deltadentialia.com/nondiscrimination.

Please complete the product forms on the following pages for any products you selected "Add" on the previous page.

**DELTA DENTAL®**

# DeltaVision®

## Vision Application

**Only complete this page if adding vision coverage.**

## BENEFIT AND RATE INFORMATION

Plan Name: ____________________

Plan Effective Date ______/ 1 /______ Renewal Date ______/ 1 /______

☐ 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: ____

## COBRA

COBRA billed to: ☐ Group ☐ Individual

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

Name and email of COBRA administrator: ____________________

## 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 contracts to be null and void.

**Signed** X ____________________ **Title** X ____________________

**Printed Name** X ____________________ **Date** X ____________

## 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 Delta Dental of Iowa.***

**Agent's Signature** X ____________________ **Date** X ____________

## ENROLLMENT REQUIREMENTS

All enrollment materials **should be sent to Delta Dental of Iowa at least 30 days prior to the effective date** of coverage to ensure delivery of identification cards and information by the effective date. Enrollment forms are **only required for employees enrolling in coverage**. Employees waiving coverage do not need to do anything.

**Materials should be sent to:**

1. TeamReNEW@deltadentalia.com
2. Delta Dental of Iowa<br>Team ReNEW<br>PO BOX 9010<br>Johnston, IA 50131-9010

DeltaVision is underwritten by Veratrus Benefit Solutions, Inc., a wholly-owned subsidiary of Delta Dental of Iowa, utilizing the EyeMed Vision Care Insight network.