DELTA DENTAL®

Large Group Application

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

☐ **Check**

DELTA DENTAL®

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.deltadentalia.com/nondiscrimination.

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

DELTA DENTAL®

Dental Application

Only complete this page if adding dental coverage.

BENEFIT AND RATE INFORMATION

Plan Effective Date _____/ 1 /_____ Renewal Date_____/ 1 /_____

Please be sure to include signed quote exhibit for requested coverage along with current benefit certificate.
For self-funded plans please include Run-In Administration Form if Delta Dental of Iowa will be processing run-in claims.

Employer Contribution:

_____ % of Employee

_____ % of Family

_____ % of Total Premium Contribution

Number of Eligible Employees: ____

Enrolling with Delta Dental: ____

Benefit accumulation period is: ☐ Calendar Year **OR** ☐ Contract Year

Prior carrier credit to be applied: ☐ Deductible/Annual Max ☐ Ortho Lifetime Max ☐ Not Applicable

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: _____

BILLING & ADMINISTRATION

Self-Funded Only:

Payment Method: ☐ Account Withdrawal (complete Payment Information section on page 1)
☐ Credit Card (complete Payment Information section on page 1)
☐ Other – please explain _____

Weekly Claims and monthly administration sent via:

☐ Email – please provide contact name/email address _____
contact name/email address _____

☐ Fax – please provide contact name/fax # _____
contact name/fax # _____

AGREEMENT AND SIGNATURE

Employer Agreement

In making this application to Delta Dental of Iowa for group dental 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 _____ Phone (_____) _____

Agency Name _____ 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, Team ReNEW,
PO BOX 9010, Johnston, IA 50131-9010

DELTA DENTAL®

DeltaVision®

Vision Application

Only complete this page if adding vision coverage.

BENEFIT AND RATE INFORMATION

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
   Team ReNEW
   PO BOX 9010
   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.

DELTA DENTAL®

Legal Application

Only complete this page if adding legal coverage.

PLAN INFORMATION

Plan Effective Date: ____ / 1 / ____
Month Day Year

Plan Choice:

☐ UltimateAdvisor® ☐ UltimateAdvisor Plus™

AGREEMENT AND SIGNATURE

Employer Agreement

In making this application to Delta Dental of Iowa for group legal 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 _____ Phone (____) _____

Agency Name _____ 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
Team ReNEW
PO BOX 9010
Johnston, IA 50131-9010

The Identity Theft Insurance is underwritten by American Bankers Insurance Company of Florida. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions. Please see the identity theft plan summary for details.

Limitations and exclusions apply. Depending on a state's regulations, ARAG's legal insurance plan may be considered an insurance product or a service product, insurance products are underwritten by ARAG Insurance Company of Des Moines, Iowa. Service products are provided by ARAG Services, LLC. This material is for illustrative purposes only and is not a contract. For terms, benefits or exclusions, call our toll-free number.

The coverage is underwritten by ARAG Insurance Company of Des Moines, Iowa.

DELTA DENTAL®

DeltaLife™

Life & Disability Form

Only complete this page if adding life and/or disability coverage.

PLAN INFORMATION

Plan Effective Date: ____ / 1 / ____
Month Day Year

Life Insurance

☐ Life Insurance
Select one:
- ☐ $10,000
- ☐ $25,000
- ☐ $50,000

--OR--

☐ _____
Proposal Number

☐ Voluntary Life Insurance

☐ _____
Proposal Number

☐ Dependent Voluntary Life Insurance

☐ _____
Proposal Number

Disability Insurance

☐ Short-Term Disability, 60% up to $1,500 for 13 weeks

Select one:	**Select one:**
☐ Employer Paid	☐ 7 Day Elimination
☐ Voluntary	☐ 14 Day Elimination

--OR--

☐ _____
Proposal Number

☐ Long-Term Disability, 60% up to $6,000 to SSNRA

Select one:	**Select one:**
☐ Employer Paid	☐ 90 Day Elimination
☐ Voluntary	☐ 180 Day Elimination

--OR--

☐ _____
Proposal Number

☐ Lump Sum Disability

Select one:	**Select one:**	**Select one:**
☐ Employer Paid	☐ $25,000	☐ 90 Day Elimination
☐ Voluntary	☐ $50,000	☐ 180 Day Elimination

--OR--

☐ _____
Proposal Number

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 _____ Phone (____) _____

Agency Name _____ 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 payroll deductions are communicated timely. A census file with employee enrollments and salary information (if applicable) will also need to be submitted to Delta Dental. Once received you will be sent a OneAmerica® application for electing and binding coverage.

Materials should be sent to:

1. TeamReNEW@deltadentalia.com

2. Delta Dental of Iowa
Team ReNEW
PO BOX 9010
Johnston, IA 50131-9010