DELTA DENTAL®

Large Employer Group Enrollment/Change Form

☐ New Applicant ☐ Change of Coverage ☐ Name/Address Change

DeltaVision®

(Completed by Employer)

Group Number _____ **Effective Date** ___/___/___ **Department/EE Number** _____

1 POLICYHOLDER INFORMATION

Name (First, Middle Initial, Last) _____ **Social Security Number** _____

Mailing Address _____ **City** _____ **State** _____ **Zip** _____

Status ☐ Single ☐ Married ☐ Other (specify) _____ **Hire Date** ___/___/___

Telephone (_____)_____ ☐ Home ☐ Cell Phone **Email Address** _____

Employer Name Camanche CSD **Employer Location** 702 13th Avenue Camanche IA 52730

2 ELIGIBLE MEMBERS ELECTING COVERAGE

Please check the DENTAL coverage you are applying for:
☐ Employee Only ☐ Employee/Spouse
☐ Employee/Child(ren) ☐ Employee/Spouse/Child(ren)

Please check the VISION coverage you are applying for:
☐ Employee Only ☐ Employee/Spouse
☐ Employee/Child(ren) ☐ Employee/Spouse/Child(ren)

List self & eligible members to be covered First Name MI Last (if different)	Social Security Number	Birthdate	Sex	Coverage Selected	Full-Time College Student	Disabled Status	Other Dental Coverage
Self		___/___/___	☐ M ☐ F	☐ Dental ☐ Vision		☐ Yes ☐ No	☐ No ☐ Yes
Spouse		___/___/___	☐ M ☐ F	☐ Dental ☐ Vision		☐ Yes ☐ No	☐ No ☐ Yes
Eligible Child		___/___/___	☐ M ☐ F	☐ Dental ☐ Vision	☐ Yes ☐ No School Name:	☐ Yes ☐ No	☐ No ☐ Yes
Eligible Child		___/___/___	☐ M ☐ F	☐ Dental ☐ Vision	☐ Yes ☐ No School Name:	☐ Yes ☐ No	☐ No ☐ Yes
Eligible Child		___/___/___	☐ M ☐ F	☐ Dental ☐ Vision	☐ Yes ☐ No School Name:	☐ Yes ☐ No	☐ No ☐ Yes

Other Dental Coverage – if any person(s) on this application has other dental insurance please complete.

Policyholder _____

Name of Other Carrier(s) _____ Policy Number _____ Effective Date ___/___/___ Contract Type ☐ **Single** ☐ **Family**

3 CHANGE OF COVERAGE

Please check events requiring Contract changes:

☐ **Marriage** ☐ **Death** ☐ **Divorce** ☐ **Birth/Adoption** ☐ **Drop Covered Person** ☐ **COBRA** ☐ **Terminating Benefits** ☐ **Part-Time to Full-Time**

☐ **Other** (explain) _____ Name of Affected Party _____ Date of Event ___/___/___

4 AGREEMENT AND CERTIFICATION

I have read and understand the Agreement and Certification and/or Waiver of Coverage language on the back of this application and acknowledge receipt of a fully completed copy of this application.

ACCEPTANCE/WAIVER OF COVERAGE

☐ I accept the dental and/or vision coverage selected above.

☐ I waive dental coverage for my family members and/or myself. (Please indicate reason) _____

☐ I waive vision coverage for my family members and/or myself. (Please indicate reason) _____

X _____ ___/___/___

Employee Signature Date

AGREEMENT AND CERTIFICATION

I certify I am legally authorized to apply for coverage for myself and/or for all other persons named in this application. I understand I am applying for coverage sponsored by my employer or Plan Sponsor offered by Delta Dental of Iowa ("Delta Dental") and/or Veratrus Benefit Solutions, Inc. ("VBS"). I authorize my employer, to deduct from my pay or collect from me in advance the premium therefore and remit such sums to Delta Dental on my behalf. This authorization is to remain in effect until I, or my employer or Plan Sponsor, notifies Delta Dental to the contrary. I understand coverage for the dental and/or vision policy applied for will not start until after this application and the monies for the first month's premium are deducted from my pay or paid to my employer, and are received and accepted by Delta Dental. I further understand that Delta Dental establishes the effective date of the policy. I also understand the amounts are subject to change at least annually and my employer or Plan Sponsor will furnish written notice of such changes to me.

I certify that after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct, to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that Delta Dental will rely upon the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or have concealed any material fact, Delta Dental will be entitled to declare the dental and/or vision policy applied for void and refuse allowance of benefits to any person thereunder.

I authorize any health care provider to release medical records to Delta Dental and VBS when reasonably related to the dental and/or vision coverage for which I have applied for. If any law or regulation requires additional authorization for release of dental and/or vision records, I will give this authorization.

WAIVER OF COVERAGE

I understand if I decide not to apply for coverage, or if I apply only for myself even though coverage is available for eligible members of my family, any subsequent application will be subject to the applicable terms and conditions of the Group Insurance Policy to provide dental and/or vision benefits, which may require additional limitations and waiting periods. I also understand Delta Dental reserves the right to reject such an application.

NONDISCRIMINATION AND ACCESSIBILITY

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 non-discrimination notice, please go to www.deltadentalia.com/nondiscrimination.