DELTA DENTAL

Small Group Enrollment/Change Dental and Vision Application

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Group Number (Completed by Employer)	Effective Date (Completed by Employer)
Dental 40159-1 Vision 34523-11	____/_____/_____
☐ New Applicant ☐ Change of Coverage ☐ Name/Address Change	Department/EE Number

SECTION I	Name (First, Middle Initial, Last)	Social Security Number	Telephone ( )
Mailing Address – Street City State Zip		Status ☐ Single ☐Married ☐ Other (specify)_____	Hire Date ___/___/___
Employer Name: City Construction		Employer Location	

SECTION II ELIGIBLE MEMBERS ELECTING COVERAGE

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

Other Dental Coverage - If any person(s) on this application has other dental insurance please complete.
Contract holder:_____

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

SECTION III CHANGE OF COVERAGE

Please check events requiring Contract changes:

☐ **Marriage** ☐ **Death** ☐ **Divorce** ☐ **Birth/Adoption** ☐ **Drop Covered Person** ☐ **COBRA** ☐ **Terminating Benefits**

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

SECTION IV 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 OF COVERAGE

_____ ____/____/____
Employee Signature Date

WAIVER OF COVERAGE

☐ 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)_____

_____ ____/____/____
Employee Signature Date

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

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 making application for the coverage sponsored by my employer or Plan Sponsor offered by Delta Dental of Iowa. 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 of Iowa on my behalf. This authorization is to remain in effect until I or my employer or Plan Sponsor notifies Delta Dental of Iowa to the contrary. I understand coverage for the dental 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 of Iowa. I further understand that Delta Dental of Iowa 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 of Iowa 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 of Iowa will be entitled to declare the dental 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 of Iowa when reasonably related to the dental coverage for which I have applied. If any law or regulation requires additional authorization for release of dental 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 of Iowa, reserves the right to reject such an application.