

Large Group Application

EMPLOYER INFORM	IATION			
Company Name			Phone ()
Address	1 (PQ P	611	CL L	7
Industry	reet (PO Box) Years in Business	City NAICS (SIC)#	State	Zip County FEIN
Decision Maker Contact	Magaz		Phone ()
Email Address	Name	Title	F	ax #
Billing Contact			Phone ()
Email Address	Name	Title	Fax	× #
(Email notification will be	e sent to billing contact nan	ned above when mont	:hly invoice is	s available to view.)
Eligibility Contact	N	7711	Phone ()
Email Address	Name	Title	F	ax #
DDODUCT SELECTIV	ON.			
PRODUCT SELECTION		Logol		Life 9 /or Disability
<u>Dental</u>	Vision	<u>Legal</u>		Life &/or Disability
☐ Add☐ Decline	☐ Add ☐ Decline	☐ Add ☐ Decline		☐ Add ☐ Decline
Already Have	☐ Already Have		lave Legal	Already Have
Delta Dental	DeltaVision®	l with Delta		DeltaLife™
	ny of the products above, plea	ise complete the produc	ct form in the	rollowing pages.
BILLING & ADMINIS	TRATION			
New hire eligibility: 1st	of month following	days 🗌 Date of hir	е	
	of month following date of I			
Coverage for Terminated	employees/dependents end	ds: Last Day of Mon	th OR La	st Day Worked
Current Medical Carrier		Previous Dental Car	rrier	
Previous Vision Carrier _		Previous Legal Ca	rrier	
Previous Life & Disability	Carrier			
PAYMENT INFORMA	TION			
	ving options to pay premium yments are not accepted.	ns. Please note, credit	card paymen	ts will include a
Account Withdrawal:				
Name of Financial Institut	ion	Brai	nch (If applica	ble)
Address of Financial Instit	ution (Street, City, State, Zip)			
Bank Routing Number	Acco	ount Number		
Credit Card:			Card type	
Name as it appears on the	e card		☐ VISA☐ Discove	☐ Mastercard er ☐ American Express
Card number Expiration date (MM/YYYY	CVV code	e (3- or 4-digit code on the		
	,	o to or raight code on the		

Delta Dental of Iowa • PO Box 9010 • Johnston, IA 50131 - 9010



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.				
<u>Self-funded Groups</u> (Dental only) I understand payments will be charged or withdrawn from the listed account based on the authorization is for the purpose of paying claims and administration fees for dental benef				
Fully Insured Groups I understand the first month's premium will be charged or withdrawn from the listed acc the month of the policy effective date, and thereafter will be charged or deducted on the 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 fu lowa has received written notification from an officer of the above named organization				
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 OF ANY KIND THAT YOU MAY INCUR AS A RESULT OF AN ERRONEOUS STATEMENT, WHICH YOUR ACCOUNT IS DEBITED, OR YOUR FAILURE TO PROVIDE ACCURATE AN	ANY DELAY IN THE ACTUAL DATE ON			
I certify to the best of my knowledge that the banking information given is not that of a outside of the United States).*	foreign banking institution (located			
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 515-26	S1-5515 for further instructions.			
AGREEMENT AND SIGNATURE				
Employer Agreement In making this application to Delta Dental of Iowa for group coverage, I agree and und of the Contract executed by an authorized officer of Delta Dental of Iowa. It is agreed the approval of Delta Dental of Iowa and that no agent or representative has authority Misrepresentation of submitted information will cause this application and subsequent	that the coverage requested is subject to to make this application for coverage.			
SignedX				
Printed Name X	Date			
Fillited Name / C	Date			
AGENT INFORMATION				
Agent Name NE	PN Insurance License			
Agency Name Ph	none ()			
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 n complied with the underwriting rules as set forth by Delta Dental of Iowa.	ny knowledge and ability, I have			
Delta Dental of Iowa complies with applicable Federal civil rights laws and does not discriminate o disability or sex. To review our full nondiscrimination notice, please go to www.deltadentialia.com/				

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

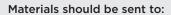


Only complete this page if adding dental coverage.

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: Number of Eligible Employees:		
% of Employee Enrolling with Delta Dental:		
% of Family % of Total Premium Contribution		
Benefit accumulation period is: Calendar Year OR Contract Year		
Prior carrier credit to be applied: Not Applicable Deductible/Annual Max/Ortho Lifetime Max (if 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		
Fully Insured Only:		
Payment Method: Account Withdrawal (complete Payment Information section on page 1) Credit Card (complete Payment Information section on page 1)		
Check 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.		
SignedX		
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		
ENDOLLMENT DECLUDEMENTS		

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.







DeltaVision®

Vision Application

Only complete this page if adding vision coverage.

BENEFIT AND RATE INFORMATION				
Plan Effective Date	/ 1 / along with current benefit certificate.			
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 complication will become part of the contract executed by an authorized officer that the coverage requested is subject to the approval of Veratrus Benefit Solutions authority to bind coverage. Misrepresentation of submitted information with contracts to be null and void.	r of Veratrus Benefit Solutions, Inc. It is agreed utions, Inc. and that no agent or representative			
Signed X	X			
Signed X Title Printed Name X	Date X			
Printed Name X				
AGENT INFORMATION Agent Name	NPN Insurance License			
AGENT INFORMATION	Date			
AGENT INFORMATION Agent Name Agency Name Email Agent's Statement: As the acting representative for this group, to the best	NPN Insurance License Phone () st of my knowledge and ability, I have			
AGENT INFORMATION Agent Name Agency Name Email Agent's Statement: As the acting representative for this group, to the best complied with the underwriting rules as set forth by Delta Dental of lowards.	NPN Insurance License Phone () st of my knowledge and ability, I have			
AGENT INFORMATION Agent Name Agency Name Email Agent's Statement: As the acting representative for this group, to the best	NPN Insurance License Phone () st of my knowledge and ability, I have			
AGENT INFORMATION Agent Name Agency Name Email Agent's Statement: As the acting representative for this group, to the best complied with the underwriting rules as set forth by Delta Dental of lowards.	NPN Insurance License Phone () st of my knowledge and ability, I have			
AGENT INFORMATION Agent Name Agency Name Email Agent's Statement: As the acting representative for this group, to the best complied with the underwriting rules as set forth by Delta Dental of loward Agent's Signature	Date X NPN Insurance License Phone () St of my knowledge and ability, I have Date X Date X O days prior to the effective date of coverage date. Enrollment forms are only required for			

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



Only complete this page if adding legal coverage.

PLAN INFORMATION		
Plan Effective Date: /_1 /		
AGREEMENT AND SIGNATURE		
part of the Contract executed by an authorized officer of Del subject to the approval of Delta Dental of Iowa and that no a	egal coverage, I agree and understand this application will become ta Dental of lowa. It is agreed that the coverage requested is gent or representative has authority to make this application for use this application and subsequent contracts to be null and void.	
Signed	Title	
Printed Name X	Date	
AGENT INFORMATION		
Agent Name NPN Agency Name	nsurance License Phone ()	
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	

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:



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.



DeltaLife™

Life & Disability Form

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

PLAN INFORMATION	
Plan Effective Date:/1/	ear ear
Life Insurance	Disability Insurance
Life Insurance \$10,000 \$25,000 \$50,000	Short-Term Disability, 60% up to \$1,500 for 13 weeks Select one: Employer Paid 7 Day Elimination Voluntary 14 Day Elimination
Voluntary Life Insurance Dependent Voluntary Life Insurance	Long-Term Disability, 60% up to \$6,000 to SSNRA Select one: Employer Paid 90 Day Elimination Voluntary 180 Day Elimination
	Lump Sum Disability Select one: Select one: Select one: Employer Paid \$25,000 90 Day Elimination Voluntary \$50,000 180 Day Elimination
AGREEMENT AND SIGNATURE	
Employer Agreement In making this application to Delta Dental of loof the Contract executed by an authorized officthe approval of Delta Dental of lowa and that references.	wa for group coverage, I agree and understand this application will become part cer of Delta Dental of Iowa. It is agreed that the coverage requested is subject to agent or representative has authority to make this application for coverage. Il cause this application and subsequent contracts to be null and void.
SignedX	Title X
Printed Name X	Date
AGENT INFORMATION	
	NEW CONTRACTOR OF THE CONTRACT
Agent Name	NPN Insurance License Phone ()
Agency Name Agent's Statement: As the acting represent complied with the underwriting rules as se	tative for this group, to the best of my knowledge and ability, I have
Agent's Signature	Date
ENROLLMENT REQUIREMENTS	
All enrollment materials should be sent to l to ensure payroll deductions are communic	Delta Dental of Iowa at least 30 days prior to the effective date of coverage cated timely. A census file with employee enrollments and salary information and to Delta Dental. Once received you will be sent a OneAmerica® application
Materials should be sent to: Team!	ReNEW@deltadentalia.com Delta Dental of Iowa Team ReNEW PO BOX 9010

Johnston, IA 50131-9010