55 Fifth Street, East
Suite 500
Saint Paul, MN 55101
Phone: 1-800-620-5010
Fax: 651-649-3502
www.directbenefits.com

Master Application – DeltaVision®

Network Administrator: EyeMed
Underwritten by Health Ventures Network
Small Business

PART A – Product Selection

☒ DeltaVision®

PART B – Client Information

Legal Company Name____

Physical Address: ______________________________ Phone (___)____________________

City _________________ State __________ Zip Code ____________________

Mailing Address ☐ Same as Physical Location ________________________________

City _________________ State __________ Zip Code ____________________

Contract Effective Date: ____

Does your company currently have a Vision plan? ☐ Yes (name of carrier) ________________ ☐ No

Does your company have a Delta Dental of Minnesota dental plan? ☐ Yes (Client Number) __________ ☐ No

Participation Requirements

Total Number of Eligible Employees ________________________________

Estimated Initial Enrollment _______ employees

☐ Employer Contribution 0-79%

- 2-10 eligible employees requires 100% participation.
- 11-100 eligible employees requires a minimum of 10 enrolled or 20% employee participation, whichever is greater

☐ Employer Contribution ≥ 80%

- 2-5 eligible employees requires 100% employee participation.
- 6-13 eligible employees requires a minimum of 5 enrolled or 75% employee participation, whichever is greater
- 14-100 eligible employees requires a minimum of 10 enrolled or 20% employee participation, whichever is greater

Please refer to your DeltaVision® proposal.

- If you are bundling your Delta Dental of Minnesota dental plan with your DeltaVision® plan, your rates will be in the category of employer contribution ≥ 80%.
- If you are buying a standalone DeltaVision® plan and your employer contribution is 0-79% then your rates follow employer contribution 0-79%.

Rates Sold

Employee (EE): $ _______ EE + Spouse: $ _______ EE + Child(ren): $_______ Family: $ _______

Client Contact Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

First Name ________________________ Last Name ________________________

Title ________________________

Contact Type: ☐ General ☐ Renewal ☐ Billing ☐ Mailing ☐ Materials

Telephone: ________________________ Ext: __________ Cell: ________________________

Fax: ________________ Email Address: ________________________

Mailing Address: ☐ Same as Client Physical Location

Street: ________________________

City ________________________ State ________________ Zip Code __________

Additional Client Contact Information (if applicable)

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

First Name ________________________ Last Name ________________________

Title ________________________

Contact Type: ☐ General ☐ Renewal ☐ Billing ☐ Mailing ☐ Materials

Telephone: ________________________ Ext: __________ Cell: ________________________

Fax: ________________

Mailing Address: ☐ Same as Client Physical Location

Street ________________________

City ________________________ State ________________ Zip Code __________

Client – Employer Services Portal Registration (ESP)

With the Employer Services Portal (ESP), you can enroll a new member, view and update existing members and view your vision plan benefits.

Select a Super User within your company and complete the information below. This Super User will receive access to the portal and is in charge of assigning user permissions within the organization. We will e-mail the Super User with registration information and additional instructions.

Client Administrator Name: ________________________ Title: ________________________

Email: ________________________ Phone Number: ________________________

Note: The Super User must be an employee of the client

PART C – DeltaVision® Program (choose one)

All programs are available for groups with 2-100 eligible employees - Annual Open Enrollment.

☐ DeltaVision®150 Materials Only - Materials Copay $10, Frame or Contact Allowance $150

☐ DeltaVision®200 Materials Only - Materials Copay $10, Frame or Contact Allowance $200

☐ DeltaVision®200 - Exam Co-pay $10, Materials Copay $25, Frame or Contact Allowance $200

PART D – Agent of Record - Completion of all fields is required including Agent Signature

Agent Name ______________________ Agency ______________________

Address ____

____

City ______________________ State __________ Zip Code ______________

Phone ______________________ E-mail Address ______________________

______________________ ______________________

Agent Signature / Insurance Agent NPN

Tax ID Number
Note: Commissions will be paid to this TIN

Agent - Employer Services Portal Registration (ESP)

Does your agency currently have a super user? ☐ Yes ☐ No

☐ Yes If yes, with the Employer Services Portal, the designated Super User for the Agent of Record can update and view the client's eligibility and access the client's billing details. The Agent/Agency will work with their Agency's Super User, who will add the appropriate user permissions to the Agent's access.

☐ No If no, Select a Super User within your company and complete the information below. We will e-mail the Super User with registration information and additional instructions.

Super User Name ______________________ Title ______________________

Email: ______________________ Phone ______________________

Agent's Signature ______________________ Date: ______________________

PART E – Billing / Payment Method

Bill Send Type: ☐ Mail ☐ Email Notification Only (Employer Services Portal)

Payment Method: ☐ ACH *Please include a completed ACH Authorization Form*

☐ Check Make check payable to: DeltaVision® and mail payments to:
DeltaVision®, NW5772, P.O. Box 1450, Minneapolis, MN 55485-5772

Check Number ____________ Amount ______________ Date Mailed ____________

PART F – Instructions

1. Complete the DeltaVision® Master Application. Retain a copy for your files.
2. Have each employee complete and sign a DeltaVision® Enrollment Form, or be identified on an approved Enrollment spreadsheet completed by the Client Administrator.
3. Send the completed DeltaVision® Master Application, Eligible/Enrolled Vision census, completed Enrollment Forms or approved Enrollment spreadsheet, and corresponding Vision Proposal to:

   Direct Benefits, Inc.
   55 Fifth Street, East, Suite 500
   Saint Paul, MN 55101

For questions call Direct Benefits at 800-620-5010

Client Administrator:

By signing below, I verify that the information on this application is correct and that the eligible employees are in fact employed by the Company (Company as named in Part B above) and agree to provide substantiating evidence when requested.

If Health Ventures Network accepts this application, a contract will be provided to Company upon acceptance. The contract will indicate the effective date of coverage. Any misrepresentations of submitted data will cause the contract, if issued, to be null and void at the option of Health Ventures Network. If issued, the contract may become null and void at the option of Health Ventures Network if for a period of three consecutive months, or upon renewal, the number of enrolled employees does not meet the participation requirements.

Any remittance of payment by Company pursuant to the contract will be considered Company's acceptance of the contract terms in full, regardless of whether Company executes the contract.

*DeltaVision is a Registered Mark of Delta Dental Plans Association

SIGNATURE BOX

______________________________ ______________________________ ______________________________

Signature of Authorized Company Official | Title | Date

______________________________ ______________________________

Client Administrator/Future Correspondence Contact (please print) | Title

______________________________ ______________________________ ______________________________

Phone Number | Fax Number | Email Address

Delta Dental of Minnesota

DIRECT DEBIT AUTHORIZATION VIA ACH (Automatic Withdrawals)

Client Name: ____________________

Client Number: ____________________

Client Sub-location Number(s): ____________________

Effective Date: ____________________

Financial Institution Information:

Bank Name: ____________________

Bank Address: ____________________

ABA (Routing) Number: ____________________

Account Number: ____________________

Type of Account: ____________________

I hereby authorize Delta Dental, subsidiaries, and affiliates to initiate automatic withdrawals (ACH) from the account indicated above in accordance with my underlying contract with Delta Dental and Delta Dental's ACH processing policies. I understand that I am responsible for any fees incurred due to the ACH being rejected or returned for any reason by my bank and collection action may be taken.

This authorization will remain in full force and effect until Delta Dental has received written notification from me of its termination in such time as to afford Delta Dental and the Financial Institution a reasonable opportunity to act on it, or until all of my payment obligations under the contract have been satisfied.

Should you have any questions regarding your Direct Debit (ACH) Instructions, please contact the Accounting Department at 1.800.906.4702 or AR@deltadentalmn.org

Mailing address: 500 Washington Avenue So, Suite 2060, Minneapolis, MN 55415

Office hours are Monday through Friday, 8 a.m. to 5 p.m. CST.

Authorized Signature: ____________________ Date: __________

Printed Name: ____________________ Phone Number __________

DELTA DENTAL

Delta Dental of Minnesota

DeltaVision®

Enrollment/Update Form

Client Name ______________________________ Dental Client/Subclient # ____________ - ____________

DeltaVision Client/Subclient (***starts with V***)# __________ - __________

PLAN ENROLLMENT/UPDATE INFORMATION (please indicate type of update and fill in appropriate information):		
Type of Update	☐ **New Enrollment** ☐ **Termination** ☐ **Change/Correction to Information** ☐ **Reinstatement** ☐ **Transfer**	
Transfer From: Client/Subclient # -	Transfer To: Client/Subclient # -	Change is for: ☐ Subscriber ☐ Dependent ☐ Spouse/Domestic Partner
FOR SOLUTIONS DUAL OPTION OR MILLENIUM CHOICE℠ PRODUCT ONLY	Select a Dental Plan Option: ☐ Plan Option I – Delta Dental PPO ☐ Plan Option II – Delta Dental Premier	

SUBSCRIBER INFORMATION (please complete for first-time enrollments and updates):				
Subscriber Name (Last)		(First)	(Middle initial)	Gender
Social Security Number - -	Birth Date (MM/DD/YYYY) / /	Coverage Effective Date (MM/DD/YYYY) / /	Hire Date (MM/DD/YYYY) / /	
Street Address			☐ Check here if this is a new address	
City	State	Zip Code	Status* ☐ Active ☐ COBRA ☐Retiree ☐Surviving	

DEPENDENT INFORMATION (please complete for dependents for first-time enrollments and updates):						
Relationship to Employee	Last Name, First Name, M.I. (Include Last Name only if different from Subscriber's)	Gender	Date of Birth (MM/DD/YYYY)	Social Security Number - requested but not required**	Status*	**Type of Coverage (select one or both: Dental/Vision)**
Spouse/ Domestic Partner					☐Legal ☐Surviving	☐Dental ☐Vision
Dependent Child					☐Legal ☐ Surviving ☐Disabled ☐Sponsored ☐Full Time Student	☐Dental ☐Vision
Dependent Child					☐Legal ☐ Surviving ☐Disabled ☐Sponsored ☐Full Time Student	☐Dental ☐Vision
Dependent Child					☐Legal ☐ Surviving ☐Disabled ☐Sponsored ☐Full Time Student	☐Dental ☐Vision
Dependent Child					☐Legal ☐ Surviving ☐Disabled ☐Sponsored ☐Full Time Student	☐Dental ☐Vision

*see reverse side for instructions and explanation of codes **Social security number only requested for dependents with same date of birth

SUBSCRIBER AND CLIENT SIGNATURE – Sign and date this form as verification of your enrollment.

☐ I am enrolling myself and/or my dependents and authorize payroll deductions, if applicable. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. I realize that any false statement or misrepresentation in the application may result in a loss of coverage under the policy.

☐ I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my Employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Delta Dental/DeltaVision reserves the right to decline any further enrollment changes.

Type of Coverage Waived *(check all that apply)*: ☐ Dental ☐ Vision

Employee Signature: ____________________________ **Date:** ________________________

Client Representative Signature______________________________________ **Date:** ________________________

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or changing any information from an earlier enrollment. If you have any questions about filling out this form, your human resources or personnel department can help you.

Plan Enrollment/Update Information - This section should only be completed if you are: (1) Enrolling yourself or a family member for the first time, or (2) if your benefits were terminated and are not being reinstated or, (3) if you are making changes to your current enrollment information.

New Enrollment:	Check for first time enrollment for yourself or your dependents.
Termination of Coverage:	Check only if you are terminating Dental or Vision coverage for yourself, your spouse or dependents.
Change/Corrections:	Check if any changes to current coverage are being submitted on the form. When reporting a change or correction, the information that is incorrect or has changed should be listed. Please include both the first and last names of any individuals for whom you are enrolling or submitting a change or correction.
Reinstatement:	Check for reinstatement coverage for yourself or your dependents.
Transfers:	Use the "Transfer From: Client#/Subclient# and Transfer To: Client #/Subclient #" When transferring from one client to another, all dependents will transfer unless otherwise indicated. This section should also be completed when transferring to COBRA.

Subscriber Information - This section must be completed for us to process your enrollment changes or corrections to your record. All information should apply to you, the primary subscriber. Please print clearly or type.

Coverage Effective Date:	The date that Dental or Vision coverage or changes take effect for you and/or your dependents.

Status Definitions (Please select only one status):

Active:	You are a current/active subscriber.
Retiree:	You are retired and your employer continues to provide you with benefits.
COBRA:	You are no longer an active subscriber but you have continued self-paid coverage under COBRA. COBRA requires many employers to offer extended self-paid coverage to certain employees and qualified beneficiaries who lose medical benefits coverage. Please check with your human resources or personnel department.

Dependent Information – This section must be completed for us to process your enrollment changes or corrections to the record(s) for a spouse, domestic partner or dependent. Please print clearly or type.

Dependent Status Definitions:

Legal:	Your current spouse.
Surviving:	The surviving spouse/domestic partner, or child of a deceased subscriber.
Disabled:	Your permanently disabled child.
Sponsored:	A dependent for whom you are legally responsible. Sponsored dependents could include parents, grandparents and foreign exchange students, but only if specified in your employer's group contract.
Full Time Student:	An individual who is your dependent child according to the U.S. Internal Revenue Code. This Student could include your married or unmarried dependent child who is attending a university, college, community college, junior college or trade school on a full-time basis and for whom you provide principal support.

Email: eligibility@mydeltadental.com

Delta Dental
Attention: Eligibility Department
PO Box 30416
Lansing, MI 48909-7916