DeltaVision®

# 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:

   **Delta Dental of Minnesota**
   **ATTN: Delta Dental Connect℠**
   **500 Washington Ave South, Suite 2060**
   **Minneapolis, MN 55415-1163**

4. Completed applications and related materials may also be emailed to:DeltaDentalConnect@DeltaDentalMN.org

**For questions call 1-800-906-5250 or DeltaDentalConnect@DeltaDentalMN.org**

**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 |