RED TREE INSURANCE COMPANY, INC.

DELTAVISION® CONTRACT APPLICATION

Please Type or Print Legibly – Blue or Black Ink Only



Northeast Delta Dental

One Delta Drive, PO Box 2002

Concord, NH 03302-2002

1-800-537-1715 – www.nedelta.com

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| 1. GROUP INFORMATION | | | | | | | | | | | | | |
| NAME OF GROUP: | |  | | | | | | | | EFFECTIVE DATE: | |  | |
| PHYSICAL ADDRESS: | |  | | | | | | | | ANNIVERSARY DATE (mm/dd): | |  | |
| CITY: | |  | | | STATE: |  | | ZIP: |  | TYPE OF INDUSTRY: | |  | |
| BILLING ADDRESS: | |  | | | | | | | | PRIOR VISION CARRIER: | | Yes | No |
| CITY: | |  | | | STATE: |  | | ZIP: |  | IF YES, CARRIER NAME: | |  | |
| GROUP ADMINISTRATIVE CONTACT: | | | |  | | | | | | TITLE: |  | | |
| TEL. #: |  | | EXT.: |  | | | FAX: |  | | E-MAIL: |  | | |
| GROUP ELIGIBILITY CONTACT: | | | |  | | | | | | TITLE: |  | | |
| TEL. #: |  | | EXT.: |  | | | FAX: |  | | E-MAIL: |  | | |

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| 2. SELECT FUNDING | |
| VOLUNTARY –  Employer contributes 0% - 49% of total premium | CONTRIBUTORY –  Employer contributes 50% - 100% of total premium |

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| 3A. SELECT PLAN OPTIONS-Exams and Hardware | | | | | | | | | | | |
| Allowances  Frames/Contact Lens | | | Co-Pays  Exam/Standard Plastic Lens | | | | | | Frequencies  Exam/Lens or Contact Lens/Frame | | |
|  | 180 / 180 | |  | | | 10 / 10 | | |  | 12 / 12 / 12 | |
|  | 150 / 150 | |  | | | 10 / 25 | | |  | 12 / 12 / 24 | |
|  | 130 / 130 | |  | | | 20 / 20 | | |  |  | |
| 3B. SELECT PLAN OPTIONS-Hardware Only | | | | | | | | | | | |
| Allowances  Frames/Contact Lens | | Co-Pays  Standard Plastic Lens | | | | | | | Frequencies  Lens or Contact Lens/Frame | | |
|  | 180 / 180 |  | | | | 10 | | |  | 12 / 12 | |
|  | 150 / 150 |  | | | | 25 | | |  | 12 / 24 | |
|  | 130 / 130 |  | | | | 20 | | |  |  | |
| 4. ENROLLMENT AND RATE INFORMATION | | | | | | | | | | | |
| Number of Membership Types | | | | 2-Tier | 3-Tier | | | 4-Tier | Rates | | Total Premium |
| Employee: | | | |  |  | | |  | $ | | $ |
| Employee + One: | | | | N/A |  | | | N/A | $ | | $ |
| Employee + Spouse: | | | | N/A | N/A | | |  | $ | | $ |
| Employee + Child(ren): | | | | N/A | N/A | | |  | $ | | $ |
| Family: | | | |  |  | | |  | $ | | $ |
| Total # of Enrollees: | | | |  |  | | |  |  | | $ |
| Rate Guarantee (No. of Months):    Months | | | | | | |  | | Include First Month’s Payment of: | |

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| 5. SELECT BILLING/PAYMENT METHOD |
| |  |  | | --- | --- | | Billing | Payment | | Monthly eBilling (Recommended)  – OR --  Monthly Invoice | Payment made through eBilling site  Recurring ACH Payments  (complete Payment Option Form located in Welcome Packet or on NEDelta.com, Employers/Forms)  Check or Money Order | |
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| |  |  |  |  | | --- | --- | --- | --- | | 6. SELECT ELIGIBILITY PERIOD | | | | | Coverage for new hired employees is effective:  First day of the month following:  Exact date of hire  Exactly       days  Other: see Additional Provision section | | Coverage for terminated employees ends:  End of month  Exact date of termination | | |  | |  | | | 7. ELECTRONIC PLAN MATERIALS |  | | 8. DOMESTIC PARTNER COVERAGE | | Go green. You will receive your plan materials electronically (initial ID cards will still be mailed). Please uncheck this box if you do not wish to receive plan materials electronically. |  | | Domestic Partner Coverage  No Domestic Partner Coverage | |

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| 9. PRODUCER INFORMATION | | | | | | | |
| PRODUCER NAME: |  | | | AGENCY NAME: |  | |
| STREET ADDRESS: |  | | | TAX ID#: |  | |
| CITY: |  | | | COMMISSIONS TO: | Producer | Agency |
| STATE: |  | ZIP: |  | CONTRACTS TO: | Producer | Group |
|  |  | | | RENEWALS TO: | Producer | Group |
| PRODUCER EMAIL: |  | | | | | |
| TELEPHONE: |  | | | FAX: |  | |
| PRODUCER SIGNATURE: | X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
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| 10. ADDITIONAL PROVISIONS | | | | | | | |
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| As a duly authorized officer/member/manager/partner/proprietor of the Applicant, I apply for the vision plan outlined above. This Application shall become part of the Group Contract for Vision Benefits (“Agreement”) and by execution of this Application, the undersigned binds the Applicant to all of the terms of the Agreement. The Agreement shall become effective on the date referenced above (the “Effective Date”), provided Red Tree Insurance Company accepts this Application. Statements in this Application are representations of the Applicant and any misrepresentations will cause the Agreement, if issued, to be voidable, at the sole option of Red Tree Insurance Company in accordance with the terms of the Agreement and applicable law. Payment of claims and determination of eligibility are contingent upon completion of this Application by the Applicant and acceptance by Red Tree Insurance Company, issuance of the Agreement by Red Tree Insurance Company, and receipt by Red Tree Insurance Company of the first payment. On behalf of the Applicant, I understand the producer, if any, will be involved in the delivery and receipt of information relating to this Application and the Agreement. I acknowledge that said producer does not have authority to approve or change this Application or the Agreement, or to waive any of their provisions. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.  All statements and descriptions in any application for insurance are deemed to be representations and not warranties.  This policy provides vision benefits only. Review your policy carefully. | | | | | | | |

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| GROUP NAME: |  |  | RED TREE INSURANCE COMPANY, INC. | |
|  |
| BY: | X |  | BY: | X |
| (Duly Authorized) | |  | (Duly Authorized) | |
| NAME  (PLEASE PRINT): |  |  | NAME: | THOMAS RAFFIO |
| TITLE: |  |  | TITLE: | PRESIDENT & CEO |
| DATE: |  |  | DATE: |  |

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| DeltaVision is underwritten by Red Tree Insurance Company, Inc., a Northeast Delta Dental company. Claims processing, claims service, and provider network administration for DeltaVision are provided under contract, by EyeMed Vision Care, LLC and its affiliate, First American Administrators, Inc. | | |
| DELTA DENTAL USE ONLY | | |
| Group Number: | Sublocation Number: | Division Number: |