DELTA DENTAL

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

1. GROUP INFORMATION

NAME OF GROUP: _____ EFFECTIVE DATE: _____

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: _____

2. SELECT FUNDING

☐ VOLUNTARY – Employer contributes 0% - 49% of total premium

☐ CONTRIBUTORY – Employer contributes 50% - 100% of total premium

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	☐ ___ / ___ / ___
☐ 100 / 115	☐ ___ / ___	
☐ 100 / 80		
☐ ___ / ___		

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:	$

5. SELECT BILLING/PAYMENT METHOD

Billing

☐ Monthly eBilling (Recommended)
– OR –
☐ Monthly Invoice

Payment

☐ 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

6. SELECT ELIGIBILITY PERIOD

Coverage for newly hired employees is effective on the first day of the month following: _____

7. 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 _____

8. ADDITIONAL PROVISIONS

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.

GROUP NAME: _____ RED TREE INSURANCE COMPANY, INC.

BY: X _____ (Duly Authorized) BY: X _____ (Duly Authorized)

NAME (PLEASE PRINT): _____ NAME: THOMAS RAFFIO

TITLE: _____ TITLE: PRESIDENT & CEO

DATE: _____ DATE: _____

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: