DELTA DENTAL®

DeltaVision®

Vision Benefits Enrollment/Change Application

Please send completed, signed application to:

E-mail – Eligibility@deltavisionmo.com

Mail -
9735 Landmark Parkway
St. Louis, MO 63127

Or call toll-free - 877-488-5130

www.deltavisionmo.com

PLEASE PRINT AND COMPLETE ALL SECTIONS.

❑ New applicant for coverage – complete sections 1, 2, 3 and 4.

❑ Change/Subscriber Authorization Form – Section 1, 3 and 4 must be completed. Complete sections 2 and 3 as applicable for change requested.

❑ I do not wish to enroll. (Declination of coverage must be accompanied by the employee's signature on the other side of this page)

SECTION 1 – EMPLOYEE INFORMATION

Group Name	**Group # / Sublocation #**	**Division/Store Location**

Employee Last Name	**First Name**	**Gender** ❑ M ❑ F

Social Security Number *	**Date of Birth** (mm/dd/yyyy) **	**Coverage Effective Date** (mm/dd/yyyy)
	___ / ___ / _____	___ / ___ / _____

Street Address

City	**State**	**Zip Code**	❑ Check here if new address

Employee Hire Date (mm/dd/yyyy) ___ / ___ / _____	**Marital Status:** ❑ Single ❑ Married ❑ Divorced ❑ Widowed

SECTION 2 – SPOUSE AND DEPENDENT INFORMATION

Please complete for spouse/dependents to be enrolled or cancelled. Use a second form for additional dependents if needed. IMPORTANT: For court-ordered dependents, legal documentation must be attached. If your dependent meets the qualifications for full-time student status, necessary documentation is required.

Level of Coverage:

❑ Employee Only ❑ Employee and Spouse ❑ Family ❑ Employee and Child(ren)

Gender ❑ M ❑ F	**Last Name (Spouse)**	**First Name**	**M.I.**	**Date of Birth **** (mm/dd/yyyy)
Gender ❑ M ❑ F	**Last Name (Dependent)**	**First Name**	**M.I.**	___/___/_____
Gender ❑ M ❑ F	**Last Name (Dependent)**	**First Name**	**M.I.**	___/___/_____
Gender ❑ M ❑ F	**Last Name (Dependent)**	**First Name**	**M.I.**	___/___/_____
Gender ❑ M ❑ F	**Last Name (Dependent)**	**First Name**	**M.I.**	___/___/_____
Gender ❑ M ❑ F	**Last Name (Dependent)**	**First Name**	**M.I.**	___/___/_____

**** Required to process enrollment***

***** Required to associate dependent(s) with subscriber***

Continued on next page. No action requested can be taken without your signature.

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DELTA DENTAL OF MISSOURI - DELTAVISION BENEFITS ENROLLMENT FORM

SECTION 3 - CHANGE OF COVERAGE

Coverage change:

☐ Employee Only ☐ Employee and Spouse ☐ Family ☐ Employee and Child(ren)

Name change:

From: Last Name: _____ First Name: _____

To: Last Name: _____ First Name: _____

Reason for change *(All changes must be made within 31 days of the qualifying event)*

Additions:

Effective date of addition: ___ / ___ / _____

☐ Birth
☐ Marriage
☐ Adoption (attach legal documentation)
☐ Court-ordered dependent (attach legal documentation)
☐ Open enrollment
☐ Other (describe) _____

Cancellations:

Effective date of cancellation: ___ / ___ / _____

☐ Death
☐ Employee terminated on ___ / ___ / _____
☐ Divorce
☐ Dependent reached student/dependent maximum age
☐ Retired
☐ Other (describe) _____

Transfer membership:

Transfer effective date: ___ / ___ / _____

From:

Group # / Sublocation #: _____

Division / Store Location: _____

To:

Group # / Sublocation #: _____

Division / Store Location: _____

SECTION 4 - EMPLOYEE AUTHORIZATION

I represent that the information I have provided on this form is complete and accurate. I request the group coverage to which I am entitled, or may become entitled, under my group's contract or the Membership Certificate/Master Policy issued to me. I authorize the proper deductions, if any, from my earnings as my contribution toward the cost of this coverage and agree that my group may act as my agent under this membership. I understand that I cannot transfer my or my dependents' right to receive benefit payments, and I agree to repay promptly any benefit payments to which I or my dependents were not entitled. I also authorize any provider of care to furnish Delta Dental of Missouri, Advantica Insurance Company, Advantica and any of their contractors, with any necessary or requested information regarding care or treatment of myself or any covered dependents. I understand that courses of vision treatment which began before my effective date may not be covered. I understand that coverage is subject to the limitations, exclusions, and waiting periods contained in the group contract and/or Membership Certificate/Master Policy. I understand that if my group has purchased an insured vision product, the insured vision product is underwritten by Advantica Insurance Company and administered by Delta Dental of Missouri and Advantica Administrative Services, Inc. I understand that if my group has purchased vision administrative services only, the vision administrative services are provided by Delta Dental of Missouri and Advantica Administrative Services, Inc.

_____ ____ / ____ / _____

Employee Signature Date

No action requested can be taken without your signature above.

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