DeltaVision® Small Group Application (2-50 enrolled employees)

Coverage by Wellness 605, Inc.
720 N Euclid Ave, Pierre, SD 57501
800-627-3961 Fax 605-224-0909
www.deltadentalsd.com

Voluntary Plans
(Employer pays less than 50% of the employee rate)

_____ Essential Plan 2

_____ Classic Plan 5

_____ Supreme Plan 16

Contributory Plans
(Employer pays more than 50% of the employee rate)

_____ Essential Plan 2

_____ Classic Plan 5

_____ Supreme Plan 16

Requested effective date _____

Group Information

Group name_____

Contact name _____ Contact phone_____

Street address_____ P.O. Box_____

City_____ State_____ Zip_____

E-mail address_____

Rates and Payment

We accept payment by electronic funds transfer. See the attached ACH form.

Does the employer pay any portion of the employee cost? If so, what percentage? _____

A four-rate structure is available for groups with 10+ employees or groups that have a medical plan with a four-rate structure. Rates are guaranteed until December 31.

Employee $_____

Family $_____ OR

Employee $_____

Emp/Spouse $_____

Emp/Children $_____

Family $_____

DeltaVision is offered in partnership with EyeMed and underwritten by Wellness 605, Inc., a wholly owned subsidiary of Delta Dental of South Dakota. DeltaVision and Delta Dental are registered marks of Delta Dental Plans Association.

Wellness 605, Inc. contracts with Delta Dental of South Dakota for certain billing and administrative matters. Your monthly invoice will be available by logging on to Delta Dental of South Dakota's website. List the e-mail address you would like us to use to notify you when your invoice is ready:

_____

Employee Information

Total number of eligible employees _____ Total number of enrollment forms submitted _____

Waiting period: new employees will be eligible on the first day of the month following _____ month(s) of employment.

Terminated employees will be covered until the last day of the month.

Employees may not change coverage for any reason other than death, divorce, or marriage except at open enrollment, January 1.

Delta Dental of South Dakota will handle COBRA paperwork on behalf of Wellness 605, Inc. for separating employees at no extra charge unless we are notified otherwise.

ID cards will be sent to the employee.

Group Signature

By signing this application, the Employer agrees and understands that it will become part of the Policy with Wellness 605, Inc. To the best of my knowledge the information included in the application is true and correct and that a material misrepresentation may cause this application and any policy to become void. If this is an application for an insured product, the coverage requested is subject to approval by Wellness 605, Inc. The Employer agrees to be bound by the terms of the policy to the extent those terms do not conflict with this application.

Printed name_____ Title_____

Signature_____ Date_____

Broker Information

As the acting representative for this group, I have to the best of my knowledge complied with the requirements listed in this application.

Broker name _____ Agency name _____

_____

Address _____ City, State and Zip _____

Phone_____ E-mail _____
_____

Broker signature _____ Date _____

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Group Authorization for Direct Payment via ACH

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Group name: _____ **Group #**: _____ **Loc #:** _____

Name: _____

Address: _____

City/State/Zip: _____ **Phone number**: _____

Email address: _____

Direct payment via ACH is the transfer of funds from a consumer account for the purpose of making a payment.

Check one: ☐ Begin payment effective _____ ☐ Change information effective _____

I authorize Wellness 605, Inc. to electronically debit my account and, if necessary, to electronically credit my account to correct erroneous debits. Funds will be drawn from your account on or around the 10th of each month.

Select one: ☐ Checking account or ☐ Savings account at the depository financial institution named below ("Depository"). I agree that ACH transactions I authorize comply with the laws of the United States and all applicable law.

Depository name: _____

Routing number: _____ **Account number**: _____

Name on the account: _____

I agree as the receiver of this authorized entry to be bound by the Nacha Operating Rules. I understand that this authorization will remain in full force and effect until I notify Wellness 605, Inc., in writing, that I wish to revoke this authorization.

Printed name: _____

Signature: ____ Date: _________________________

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DeltaVision®
Coverage by Wellness 605, Inc.

Enrollment/Change Form

Effective date: ______________

720 N Euclid Ave, Pierre, SD 57501
800-627-3961 Fax 605-224-0909

Hire date: ____________________

Group name: ____ Group number: ____________________

Employee name: ____ SSN: __________________

Mailing address: ____ Birth date: __________________

City/State/Zip: ____ Gender: ___M ___F

Cell phone* ___________________ Email:* ___________________________________

Marital status (we do not recognize common law marriage): Single ___ Married ___

Add or Drop	First Name	Last Name	Birth Date	Gender	Coverage Type
☐Add ☐Drop	Spouse				☐Dental ☐Vision

Cell phone* ______________________ Email* ______________________________________

Add or Drop	First Name	Last Name	Birth Date	Gender	Coverage Type
☐Add ☐Drop	Child				☐Dental ☐Vision

Cell phone* ______________________ Email* ______________________________________

Add or Drop	First Name	Last Name	Birth Date	Gender	Coverage Type
☐Add ☐Drop	Child				☐Dental ☐Vision

Cell phone* ______________________ Email* ______________________________________

Add or Drop	First Name	Last Name	Birth Date	Gender	Coverage Type
☐Add ☐Drop	Child				☐Dental ☐Vision

Cell phone* ______________________ Email* ______________________________________

Change in coverage

Marriage date: ___________________________________ Divorce date: ______________________________

Other (explain): _________________________________ Date of change: ____________________________

Signature: ____ Date: __________________

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Delta Dental (DDSD) Coverage I accept the dental insurance provided by my employer and allow payroll deductions toward the cost of insurance (if any). I understand that I need to remain enrolled and cannot make a change in coverage until the next open enrollment period.

Wellness 605, Inc. Coverage I accept the vision insurance provided by my employer and allow payroll deductions toward the cost of insurance (if any). I understand that I need to remain enrolled and cannot make a change in coverage until the next open enrollment period.

Waiver of Coverage If I decide not to apply for coverage, or if I apply only for single coverage even though I am eligible for family coverage, any future enrollment form will be subject to the terms and conditions of my employer's Policy. I also understand that DDSD and Wellness 605, Inc. reserve the right to reject the enrollment form.

* I agree to let DDSD and Wellness 605, Inc. use this information for surveys for people over 18. Email and text messages may not be secure.