



UNIVERSITY OF IOWA EMPLOYEES

ENROLLMENT/CHANGE FORM

Please print and complete all sections. See instructions below.

Offered through Veratus Benefit Solutions, Inc., a wholly-owned subsidiary of Delta Dental of Iowa

FOR BEST RESULTS: Download this pdf and complete by using Adobe Acrobat Reader.

EMPLOYER INFORMATION:

Group Number 9716184 | University of Iowa Employees | University of Iowa Voluntary Vision Plan

Effective Date _____ Other _____

EMPLOYEE INFORMATION: A: Add (enroll) T: Terminate C: Change (change of name, address or phone)

Employee information fields including Sex, Last Name, First Name, M.I., Date of Birth, Date of Hire, University ID Number, Social Security #, Home Phone, Home Street Address, City, State, Zip.

FAMILY INFORMATION: (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name)

Family information field 1: Last Name (spouse), First Name, M.I., Date of Birth (Month/Day/Year)

Family information field 2: Last Name (dependent), First Name, M.I., Date of Birth (Month/Day/Year)

Family information field 3: Last Name (dependent), First Name, M.I., Date of Birth (Month/Day/Year)

Family information field 4: Last Name (dependent), First Name, M.I., Date of Birth (Month/Day/Year)

Family information field 5: Last Name (dependent), First Name, M.I., Date of Birth (Month/Day/Year)

Family information field 6: Last Name (dependent), First Name, M.I., Date of Birth (Month/Day/Year)

Employee Signature _____ Date _____

INSTRUCTIONS:

- Employer name: Legal name of the employer.
Group Number: Provided by carrier.
Effective date: Date set by employer in accordance with EyeMed proposal.
Family Information: List only eligible family members who are enrolling.
(A) Add: Open (group) enrollment or new (individual) enrollment during the contract period.
(T) Terminate: To terminate enrollment.
(C) Change: A change of name, employee address or employee phone.

YOUR AUTHORIZATION:

Table with 2 columns: Authorization description and amount. Includes Per Employee only per month (\$8.82), Per Employee + spouse per month (\$16.44), Per Employee + child(ren) per month (\$16.90), Per Employee + family per month (\$24.14).

SEND FORM TO:

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