DeltaVision® eye Med

UNIVERSITY OF IOWA EMPLOYEES

ENROLLMENT/CHANGE FORM

Please print and complete all sections. See instructions below.

Offered through Veratrus 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 35646 | 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)

○ A ○ T ○ C | Sex ○ M ○ F

Last Name (Employee or subscriber) ________________ First Name ________________ M.I. ______

Date of Birth ________ Date of Hire ________ Employee ID Number ________ (7 characters long - begins with a 1)

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)

○ A ○ T ○ C | Sex ○ M ○ F

Last Name (spouse) ________________ First Name ________________ M.I. ________

Date of Birth ________________ (Month/Day/Year)

○ A ○ T ○ C | Sex ○ M ○ F

Last Name (dependent) ________________ First Name ________________ M.I. ________

Date of Birth ________________ (Month/Day/Year)

○ A ○ T ○ C | Sex ○ M ○ F

Last Name (dependent) ________________ First Name ________________ M.I. ________

Date of Birth ________________ (Month/Day/Year)

○ A ○ T ○ C | Sex ○ M ○ F

Last Name (dependent) ________________ First Name ________________ M.I. ________

Date of Birth ________________ (Month/Day/Year)

○ A ○ T ○ C | Sex ○ M ○ F

Last Name (dependent) ________________ First Name ________________ M.I. ________

Date of Birth ________________ (Month/Day/Year)

○ A ○ T ○ C | Sex ○ M ○ F

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. Employer also sets effective date for new adds during contract period.

Family Information: List only eligible family members who are enrolling. Dependent eligibility is the same as employer's health plan.

(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:

I authorize vision plan payroll deduction for:

Per Employee only per month	$9.00
Per Employee + spouse per month	$16.78
Per Employee + child(ren) per month	$17.24
Per Employee + family per month	$24.62

SEND FORM TO:

Email: benefitiowa@worldinsurance.com
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Fax: 515-327-2021