Delta Dental of Illinois Supplemental Questionnaire for Group/Employer DeltaVision® Policy

GROUP/EMPLOYER INFORMATION

Group/Employer Name _____

INITIAL ENROLLMENT

Total number of eligibles: _____ Total number of eligible enrolled: _____

GROUP/EMPLOYER CONTRIBUTION FOR DELTAVISION*

The **group/employer** contributes:

☐ $_____ or _____% of the cost of the member's insurance.

$_____ or _____% of the cost of one or more dependents' insurance.

☐ None (Coverage is voluntary)

ELIGIBILITY INFORMATION

PLEASE INDICATE ELIGIBILITY REQUIREMENTS FOR ENROLLMENT UNDER THE GROUP/EMPLOYER POLICY. *Enrollment under the group/employer policy will include:*

Is the eligibility the same for DeltaVision as for the Group/Employer Dental Policy? ☐ Yes ☐ No
If no, please specify: _____

New Hire Eligibility Date:

Is the new hire date the same as the Group/Employer Dental Policy? ☐ Yes ☐ No
If no, please specify: _____

Termination Occurs On:

Is the termination date the same as the Group/Employer Dental Policy for members? ☐ Yes ☐ No
If no, please specify: _____

Is the termination date the same as the Group/Employer Dental Policy for dependents? ☐ Yes ☐ No
If no, please specify: _____

Limiting Age

Fully Insured: The limiting age for covered unmarried dependent children is 26.

PREMIUM PAYMENTS

Is the delivery of premium payments the same for DeltaVision as for the Group/Employer Dental Policy? ☐ Yes ☐ No
If no, please specify: _____

REMARKS/ADDITIONAL INFORMATION

_____

Please note: Attach your selected plan design with accepted rates/fees when submitting this form.

**DeltaVision is provided by ProTec Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, in association with EyeMed Vision Care networks.*

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