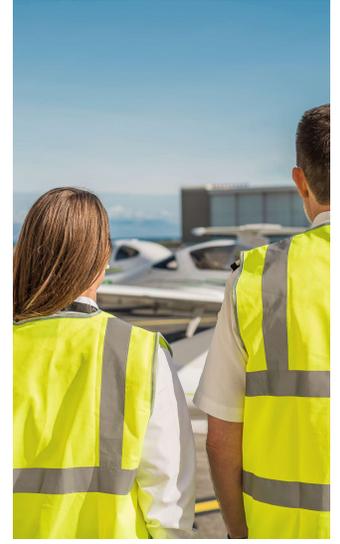


2025 - 2026 Employee Benefit Booklet



This guide highlights the main features of many of the benefit plans sponsored by Des Moines Airport Authority. Full details of these plans are contained in the legal documents governing the plans. If there is any discrepancy between the plan documents and the information described here, the plan documents will govern. In all cases, the plan documents are the exclusive source for determining rights and benefits under the plans. Participation in the plans does not constitute an employment contract. Des Moines Airport Authority reserves the right to modify, amend or terminate any benefit plan or practice described in this guide. Nothing in this guide guarantees that any new plan provisions will continue in effect for any period of time.



2025 - 2026

Employee Benefits Highlights

If you are a full-time employee scheduled to work at least 30 hours per week, you are eligible to participate in the Medical, Dental, and Vision Plans. If you do not wish to make any changes, your benefits will rollover from what you currently have elected. **If you would like to make changes, you need to submit enrollment forms to Human Resources by June 18.** Benefits will be effective July 1, 2025 through June 30, 2026.

Medical Plan Summary

\$500 DEDUCTIBLE PLAN		
	In-Network	Out-of-Network
ANNUAL DEDUCTIBLE (Calendar year)		
Individual	\$500 (\$3,000)	\$500 (\$3,000)
Family	\$1,000 (\$6,000)	\$1,000 (\$6,000)
ANNUAL OUT-OF-POCKET MAXIMUM (Calendar year)		
Individual	\$1,000 (\$6,000)	\$1,000 (\$6,600)
Family	\$2,000 (\$12,000)	\$2,000 (\$13,200)
COINSURANCE/COPAYS		
Preventive Care	Covered at 100%	Deductible, 40% Coinsurance
Primary Care Physician	Designated PCP - \$20 Copay Non-Designated PCP - \$35 Copay	Deductible, 40% Coinsurance
Specialist	\$50 Copay	Deductible, 40% Coinsurance
Doctor On Demand	\$15 Copay	Not Covered
Chiropractor and Physical Therapy	\$25 Copay	Deductible, 40% Coinsurance
Urgent Care	\$35 Copay	Deductible, 40% Coinsurance
Emergency Room	\$350 Copay	\$350 Copay
Inpatient/Outpatient Hospital Care	Deductible, 10% Coinsurance	Deductible, 40% Coinsurance
PRESCRIPTION DRUGS (Blue Rx Complete Formulary)		
Retail (30-day supply)	Tier 1 \$25 Copay / Tier 2 \$50 Copay / Tier 3 \$100 Copay	N/A
Specialty Drugs	Generic \$160 Copay / Preferred \$225 Copay / Non-Preferred \$275 Copay	
Mail Order (90-day supply)	3x Copay	N/A
PER PAYCHECK CONTRIBUTIONS		
MEDICAL PREMIUMS	EMPLOYEE	EMPLOYER
Employee Only	\$18.96	\$222.19
Family	\$47.39	\$534.71

Annual Authority Medical or FSA Contribution

If you are enrolled in a Medical Flexible Spending Account, the Authority will contribute \$480 to it annually. If you would rather have that contribution put towards your health insurance premium instead, please indicate on your enrollment form.

PARTIALLY SELF-FUNDED MEDICAL PLAN

Des Moines Airport Authority purchases a \$3000 PPO deductible plan from Wellmark and buys down the deductible and out-of-pocket maximum through Employee Benefit Services. The deductible and out-of-pocket amounts you are responsible for are listed on the previous page in bold. If you incur a claim that exceeds the amounts you are responsible for, the claim will be processed automatically and the EBS will pay the claim directly to your provider. Below is an example of how claims flow through EBS.

You incur a claim at the hospital

The hospital submits your claim to Wellmark

Wellmark sends Explanation of Benefits (EOB) to both you and EBS.

EBS re-processes the claims according to the lower deductible Partial self-funded plan.

EBS will send a final EOB to you. If you have met your maximum deductible and OOPM, EBS will send a check to the provider. If you have not met it then you will be responsible for what is on the EOB.

NOTE: You will receive an EOB from both Wellmark and EBS. The EOB from Wellmark does not take into account the Partially self-funded plan, so it is best practice to wait until you receive the final EOB from EBS to pay your bill.



DENTAL COVERAGE

Des Moines Airport Authority offers a dental PPO plan through Delta Dental of Iowa. The plan provides you and your family with coverage for typical dental expenses, such as cleanings, X-rays, fillings, and orthodontia for children.

	PPO	Premier/Non-Participating
DEDUCTIBLE		
Individual	\$15	\$25
Family	\$45	\$75
BENEFITS		
Individual Annual Maximum	\$1,250	\$1,250
Diagnostic & Preventive <i>Exams/cleanings, Fluoride, x-rays, sealants</i>	100%	100%
Regular Restorative Services <i>Emergency</i> <i>Treatment, fillings, surgical services</i>	90%	80%
Crowns, Inlays/Onlays, Periodontics (conservative), Endodontics	80%	80%
Major Services <i>Dentures,</i> <i>Periodontics (complex), Bridges, Implants</i>	50%	50%
Orthodontics (Adult & Child)	50%	50%
PER PAYCHECK CONTRIBUTIONS		
DENTAL PREMIUMS	EMPLOYEE	EMPLOYER
Employee Only	\$0	\$30.64
Family	\$0	\$51.42

VISION COVERAGE

Des Moines Airport Authority's vision plan is administered by Avesis. The plan covers services such as eye exams, lenses, frames, and contact lenses. And, when you use an Avesis network provider, you will receive a discount on your vision care services.

	In-Network	Out-of-Network Reimbursements
Materials Copay	\$25	N/A
Frame Allowance <i>(Once every 24 months)</i>	\$50 Wholesale allowance up to \$150	Up to \$45
Spectacle Lenses <i>(Once every 12 months)</i>	Covered in full after \$25 Copay	Up to \$25
Single		Up to \$40
Bifocal		Up to \$50
Trifocal		Up to \$80
Lenticular		N/A
Contact Lenses <i>(Once every 12 months)</i>	\$130 Allowance Covered in full	Up to \$130
Elective		Up to \$250
Medically Necessary		
Lasik Surgery <i>(One time allowance)</i>	\$150 Allowance; Provider discount up to 25%	\$150 Allowance
PER PAYCHECK CONTRIBUTIONS		
VISION PREMIUMS	EMPLOYEE	EMPLOYER
Employee Only	\$0	\$1.71
EE + Sp	\$1.29	\$1.71
EE + Child(ren)	\$1.89	\$1.71
Family	\$2.75	\$1.71

Additional Benefits

Benefit	Plan Summary	Employee Cost								
Group Term Life Insurance <i>(Automatically enrolled upon hire)</i>	2x Annual Base Pay	No cost to Employee								
Supplemental Life Insurance <i>(Open for enrollment October 2025)</i>	Additional Employee, Spouse and Child term life options	Employee Paid								
Long Term Disability <i>(Automatically enrolled upon hire)</i>	90-Day wait, 66.6% benefit	No Cost to Employee								
Flexible Spending Account <i>(Open for enrollment October 2025)</i>	Medical Flexible Spending Account and Dependent Care Flexible Spending Account	Authority contribution of \$480 per year to Medical Flex Employee can contribute up to IRS Limit								
Post-Employment Health Plan	Medical Reimbursement Account for post-employment	Authority contribution of \$1,050								
Pension Plan	Iowa Public Employers Retirement System (IPERS)	Employee contribution: 6.29% Authority contribution: 9.44%								
Deferred Compensation	401A – 4.5% Airport match OR 457 – 4.5% Airport match OR 457 Roth – 4.5% Airport match Payroll Roth IRA	Employee can contribute up to IRS max. Employee Contribution only.								
Tuition Reimbursement	Books and tuition reimbursement for a degree seeking program	\$2,400 per year reimbursed after qualifying grade of C								
Sick Leave	Accrues at 1 day per month. Unused sick leave payout at Retirement	No Cost to Employee								
Holiday Leave	11 paid holidays per year	No Cost to Employee								
Vacation Leave	<table border="1"> <thead> <tr> <th><u>Years of Service</u></th> <th><u>Vacation Hours</u></th> </tr> </thead> <tbody> <tr> <td>< 5 years</td> <td>120</td> </tr> <tr> <td>5-19 years</td> <td>160</td> </tr> <tr> <td>20+ years</td> <td>200</td> </tr> </tbody> </table>	<u>Years of Service</u>	<u>Vacation Hours</u>	< 5 years	120	5-19 years	160	20+ years	200	No Cost to Employee
<u>Years of Service</u>	<u>Vacation Hours</u>									
< 5 years	120									
5-19 years	160									
20+ years	200									



Group Employee Application for Health Insurance

Wellmark Blue Cross and Blue Shield of Iowa and Wellmark Health Plan of Iowa, Inc. are independent licensees of the Blue Cross and Blue Shield Association.

Wellmark Blue Cross and Blue Shield of Iowa
updatesgroupmembership@wellmark.com

Failure to fill out this application completely may result in a delay of coverage.

Effective Date ____/____/____

Special Enrollee Change Open Enrollment Period Newly Eligible

A. Employer Information (Completed by Employer)

Employer Name _____
Employer Group Number _____ Subgroup Number _____
Department Number _____

B. Employee Information

Name (First, MI, Last) _____
Address Line 1 (Street Address or Suite#) _____
Address Line 2 (PO Box, Street Address) _____
City _____ State _____ ZIP _____
Home Phone Number (____) _____ Cell Phone Number (____) _____
Email Address _____

Date of Birth ____/____/____ (mm/dd/yyyy) Gender: Male Female Status: Single Married

Social Security Number/Tax Identification Number _____
(Social Security Number (SSN) or Tax Identification Number (TIN) must be provided.)

Date of Hire (required) ____/____/____ (mm/dd/yyyy)

Employment Status: Full-Time Part-Time COBRA Retiree Seasonal

Health: Employee Employee/spouse Employee/child(ren) Employee/spouse/child(ren)

Health Product ID* _____ Not Elected

*If you're enrolling in an HMO/WHPI plan a Primary Care Provider (PCP) must be elected for each family member. Please visit www.myWellmark.com to select your PCP.

As a Wellmark contract holder, you will receive a Summary of Benefits and Coverage (SBC) that outlines important information about your coverage. You can also access Wellmark.com/Inform to help you make the best decisions for you and your family. This site includes important information on your prescription drug coverage, like the accessibility and availability of prescription drugs, how to request a current drug list and the process for requesting an exception to the drug list. You also can find a list of participating providers and facilities, and how to obtain a prior authorization. For more information, or if you have any questions, you can call the Wellmark Customer Service number located on the back of your ID card.

C. Enrollment Reason or Event

Special Enrollment Event Reason:

- | | |
|---|--|
| <input type="checkbox"/> Birth | <input type="checkbox"/> Legal guardianship |
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Foster child placement |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Involuntary loss of creditable coverage |
| <input type="checkbox"/> Adoption or placement for adoption | <input type="checkbox"/> Permanent move to Iowa |
| <input type="checkbox"/> Court-ordered coverage | <input type="checkbox"/> Returning from military service |
| <input type="checkbox"/> Other _____ | |

List date of special enrollment event ____/____/____ (mm/dd/yyyy) (or last day of coverage)

Employee Name (First, Last)	Social Security Number / Tax Identification Number
-----------------------------	--

D. Members/enrollees Covered If you need to list more than four dependents, please write all necessary information on a separate sheet of paper and attach to this application. Your employer determines eligibility for coverage. Please confirm with your employer that the dependent types listed below are eligible.

Name (First, MI, Last)	Date of Birth (mm/dd/yyyy)	Social Security Number/ Tax Identification Number ¹	Gender	FT Student? ²	Disabled? ²
Spouse	/ /	a. <input type="checkbox"/> SSN/TIN _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	N/A	<input type="checkbox"/> Yes
Dependent	/ /	a. <input type="checkbox"/> SSN/TIN _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Dependent	/ /	a. <input type="checkbox"/> SSN/TIN _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Dependent	/ /	a. <input type="checkbox"/> SSN/TIN _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Dependent	/ /	a. <input type="checkbox"/> SSN/TIN _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

¹The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Your employer will follow up with you to collect this information if you do not complete a. or b. for each person listed. Failure to provide the SSN/TIN information may result in a monetary penalty, per violation, assessed to you by the IRS.

²If your plan covers dependent(s) age 26 or older, they must be unmarried and either a full-time student or a disabled dependent. Please contact your Wellmark representative for more information.

E. Medicare Coverage

Are you and/or anyone listed in the Dependent Information section Social Security disabled? Yes No
 If yes, name _____
 Are you and/or anyone listed in the Dependent Information section enrolled in Medicare? **(Absence of a response will be considered as a response of "No")** Yes No
 If yes, complete as appropriate:

Name ³	Medicare ID	Effective Dates		
		Part A	Part B	Part D
		/ /	/ /	/ /
		/ /	/ /	/ /

³If you need to list more than two members, please write all necessary information on a separate piece of paper and attach to this application.

Employee Name (First, Last)	Social Security Number / Tax Identification Number
-----------------------------	--

F. Other Health Coverage Information (Required)

Yes No Will you, your spouse, or your dependents keep other health coverage in addition to this Wellmark, Inc. coverage?
 If yes, please complete the following:
 Policyholder Name (First and Last) _____
 Please list those covered by the other health plan(s) _____
 Policy Number _____ Effective Date ____/____/____
 Insurance Company/HMO Name _____
 Is there a divorce decree/court order that requires one parent to provide health insurance coverage for any dependent?
 Yes No If yes, please complete the following:
 List dependent(s) _____
 List name of person required to provide health insurance _____
 List name of person who has primary physical custody _____

G. Important Information Regarding Waiver Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage), or if you lose eligibility for coverage under Medicaid or CHIP or become eligible for Medicaid or CHIP premium assistance. You may be able to enroll if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption. However, you must request enrollment within the time specified by your employer or group sponsor after the qualifying event.

Please note that if you or your dependents are not covered by minimum essential coverage, you may be responsible for individual shared responsibility payments when filing your federal income tax return. Also, by declining the coverage offered by your employer, you or your dependents may not be eligible for Marketplace coverage subsidies.

To request special enrollment or obtain more information, refer to your Summary Plan Description (SPD), coverage manual, other benefits documents, or contact your employer.

H. Authorization and Certification

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I understand that I am completing this application for the coverage sponsored by my employer or group sponsor and offered by Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa, or Wellmark Health Plan of Iowa, Inc. (each referenced herein as "Wellmark").

I certify that, after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that my employer or group sponsor will rely on the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or concealed any material fact, my employer or group sponsor is entitled to declare the contracts applied for void and to refuse allowance on benefits to any person thereunder. I understand and grant authorization for my employer, group sponsor, consultant, or Wellmark agent to electronically submit the information provided by me on this signed application for enrollment purposes.

I acknowledge I have received or have been advised and understand I will receive from my employer the Summary of Benefits and Coverage (SBC).

Providing Social Security Numbers or Tax Identification Numbers
 Wellmark requires Social Security numbers or other tax identification numbers for federal reporting purposes. If Wellmark does not have Social Security or tax identification numbers for each enrollee, Wellmark or my employer may be unable to report and send information needed to complete federal tax returns. If Social Security numbers or tax identification numbers are not provided for all individuals covered, Wellmark or my employer may contact the primary policyholder to obtain the information. If I do not provide the Social Security numbers or tax identification numbers for these purposes, I may be subject to a monetary penalty imposed by the internal revenue service.

HSA Coverage
 In the event I have selected a High Deductible Health Plan, I understand that enrolling in such coverage does not guarantee that I am or will be eligible to make contributions to an HSA or that contributions can be made to an HSA on my behalf.

Employee Name (First, Last)	Social Security Number / Tax Identification Number
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H. Authorization and Certification, cont'd.

Consent to Contact Me Via Residential Telephone, Cellular Phone, Text and Email Messages

By checking the box and entering my signature on this application, I hereby provide my consent to Wellmark to contact me about Wellmark policy or products and services that may be available to me. Wellmark may provide this information to me using residential telephone, cellular telephone or wireless device, text message or email contact information provided to Wellmark from time to time. If I provide a telephone number for voice calls, I understand that Wellmark may contact me via live or prerecorded calls. I give Wellmark permission to use my personal data (including personally identifiable information) in accordance with Wellmark's privacy policy to determine the types of products and services that may be offered to me. I understand the telephone company or other communications carrier may impose charges for these contacts and that I am not required to give this consent to purchase any goods or services. I understand I may revoke this consent at any time by calling the number located on the back of my Wellmark ID Card.

I understand that I have the right to refuse to sign this authorization, but that Wellmark will then have the right to condition eligibility determination and enrollment on the receipt of this signed authorization.

I authorize the Wellmark agent or agency who is identified with this application or my employer's group application to enter my application information through Wellmark's electronic enrollment process. In the event of any discrepancy between this paper application form and the information entered electronically may be considered the source of records, and I may contact Wellmark to make any changes to my enrollment information. Wellmark authorized agents are required to retain this original paper application for 11 years.

I have read and understand the Important Information Regarding Waiver of Enrollment and Authorization and Certification language on this application and acknowledge receipt of a fully completed copy of this application.

Employee Signature _____ **Date** ____/____/____

If applicant is a minor, please sign below.
Parent/Legal Guardian Printed Name: _____

Parent/Legal Guardian Signature: _____ **Date** ____/____/____

Wellmark Language Assistance

Discrimination is against the law

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. Wellmark does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Wellmark

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 3E417, Des Moines, IA 50309-2901, 515-376-6500, TTY 888-781-4262, Fax 515-376-9055, Email CRC@Wellmark.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
 200 Independence Avenue, SW
 Room 509F, HHH Building
 Washington, D.C. 20201
 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线：888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobu oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

ສິ່ງຄວນເຂົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານ ໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ທີ. (TTY: 888-781-4262).

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें: अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, नि:शुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION: Si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deutsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิด ค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တစ်ခုသို့ပြည်-နယ်ကတိကဉ်ကိတ်. ကိုတိတ်မေးတတ်မေးတတ်, လာတတ်လက်ကားလဲ, ဆိုလဲနုဂီလီဆဲးကိတ်ဆူ ၈၀၀-၅၂၄-၉၂၄, ၈၈၈-၇၈၁-၄၂၆ (TTY: ၈၈၈-၇၈၁-၄၂၆) တက်ကု.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ । 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस् ।

ማሳሰቢያ: ከማርኛ የሚናገሩ ከሆነ፣ የቋንቋ አገዛ አገልግሎቶቹ፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ደውሎ ያነጋግሩ።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maada. Hebir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnaama.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'éhjí yánílti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojí' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

New Applicant Change of Coverage Name/Address Change

Employer Choice

(Completed by Employer)

Group Number _____ Effective Date ____/____/____ Department/EE Number _____

1 POLICYHOLDER INFORMATION

Name (First, Middle Initial, Last) _____ Social Security Number _____

Mailing Address _____ City _____ State _____ Zip _____ Status Single Married Hire Date ____/____/____
 Other (specify) _____

Telephone (____) _____ Home Cell Phone Email Address _____

Employer Name _____ Employer Location _____

2 ELIGIBLE MEMBERS ELECTING COVERAGE

List self & eligible members to be covered			Social Security Number	Birthdate	Sex	Full-Time College Student	Disabled Status	Other Dental Coverage
First Name	MI	Last (if different)						
Self				____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No <input type="checkbox"/> Yes
Spouse				____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eligible Child				____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eligible Child				____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eligible Child				____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No School Name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No <input type="checkbox"/> Yes

Other Dental Coverage - if any person(s) on this application has other dental insurance please complete.

Policyholder _____

Name of Other Dental Carrier(s) _____ Policy Number _____ Effective Date ____/____/____ Contract Type Single Family

3 CHANGE OF COVERAGE

Please check events requiring Contract changes:

Marriage Death Divorce Birth/Adoption Drop Covered Person COBRA Terminating Benefits Part-Time to Full-Time
 Other (explain) _____ Name of Affected Party _____ Date of Event ____/____/____

4 AGREEMENT AND CERTIFICATION

I have read and understand the Agreement and Certification and/or Waiver of Coverage language on the back of this application and acknowledge receipt of a fully completed copy of this application.

ACCEPTANCE/WAIVER OF COVERAGE

I accept the dental coverage selected above.
 I waive dental coverage for my family members and/or myself. (Please indicate reason) _____

X _____ Date ____/____/____
 Employee Signature Date

AGREEMENT AND CERTIFICATION

I certify I am legally authorized to apply for coverage for myself and/or for all other persons named in this application. I understand I am applying for coverage sponsored by my employer or Plan Sponsor offered by Delta Dental of Iowa ("Delta Dental"). I authorize my employer, to deduct from my pay or collect from me in advance the premium therefore and remit such sums to Delta Dental on my behalf. This authorization is to remain in effect until I, or my employer or Plan Sponsor, notifies Delta Dental to the contrary. I understand coverage for the dental policy applied for will not start until after this application and the monies for the first month's premium are deducted from my pay or paid to my employer, and are received and accepted by Delta Dental. I further understand that Delta Dental establishes the effective date of the policy. I also understand the amounts are subject to change at least annually and my employer or Plan Sponsor will furnish written notice of such changes to me.

I certify that after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct, to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that Delta Dental will rely upon the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or have concealed any material fact, Delta Dental will be entitled to declare the dental and/or vision policy applied for void and refuse allowance of benefits to any person thereunder.

I authorize any health care provider to release medical records to Delta Dental when reasonably related to the dental coverage for which I have applied for. If any law or regulation requires additional authorization for release of dental and/or vision records, I will give this authorization.

WAIVER OF COVERAGE

I understand if I decide not to apply for coverage, or if I apply only for myself even though coverage is available for eligible members of my family, any subsequent application will be subject to the applicable terms and conditions of the Group Insurance Policy to provide dental benefits, which may require additional limitations and waiting periods. I also understand Delta Dental reserves the right to reject such an application.

NONDISCRIMINATION AND ACCESSIBILITY

Delta Dental of Iowa complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. To review our full non-discrimination notice, please go to www.deltadentalia.com/nondiscrimination.



I am Waiving Vision Insurance

AVĒSIS ADVANTAGE VISION CARE EMPLOYEE ENROLLMENT FORM

PLEASE PRINT LEGIBLY

Underwritten by Fidelity Security Life Insurance Company® Kansas City, Missouri

Policy No. VC-16

TO BE COMPLETED BY THE EMPLOYEE

Employee Last Name		Employee First Name		MI
Date of Birth / /	Social Security Number - -		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address				Apartment No.
City		State	Zip Code -	

Do you wish to cover your eligible dependents? Yes No

If yes, complete the following:

	Dependent Name	Date of Birth
Spouse/Domestic Partner		/ /
Child		/ /

I would like to cover additional eligible dependents (PLEASE LIST ON A SECOND ENROLLMENT FORM)

By signing below, I agree to receive all documents and correspondence electronically and that I can access the internet or the email address provided. I understand that I may revoke this authorization or request specific paper documents without revoking this authorization by contacting the Company [or Administrator] by mail, email, or telephone.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I authorize deductions from my earnings at the required contributions towards the cost of the coverage.	
Signature	Date / /

TO BE COMPLETED BY THE EMPLOYER

<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Add ○ Dependents	<input type="checkbox"/> Change ○ Address ○ Phone ○ Name ○ COBRA	<input type="checkbox"/> Cancel Coverage ○ Policy Holder ○ Dependent(s)
Reason for Change	<input type="checkbox"/> Employment Status <input type="checkbox"/> Qualifying Event: (PLEASE STATE) _____		
Requested Effective Date / /	Date of Employment / /		