



RED TREE INSURANCE COMPANY, INC.
DELTAVISION® CONTRACT APPLICATION
 PLEASE TYPE OR PRINT LEGIBLY — IN BLUE OR BLACK INK ONLY

Northeast Delta Dental
 One Delta Drive
 PO Box 2002
 Concord, NH 03302-2002
 800-537-1715
 www.nedelta.com

GROUP INFORMATION

| | | | | | |
|-------------------------------|------------|-----------|-------------------|--|--|
| Name of Group: | | | Effective Date: | | |
| Physical Address: | | | Type of Industry: | | |
| City: | State: | ZIP Code: | Anniversary Date: | | |
| Billing Address: | | | | | |
| City: | State: | ZIP Code: | | | |
| Group Administrative Contact: | | | Title: | | |
| Telephone: | Extension: | Fax: | E-mail: | | |
| Group Eligibility Contact: | | | Title: | | |
| Telephone: | Extension: | Fax: | E-mail: | | |

| Vision Benefits: | Options 1 – 3 | | | Options 4 – 6 | | | Options 7 – 9 | | |
|-------------------------------|----------------------|-------|-------|----------------------|-------|-------|----------------------|-------|-------|
| Allowances: | | | | | | | | | |
| Frames | \$ 130 | | | \$ 100 | | | \$ 100 | | |
| Contacts | \$ 130 | | | \$ 115 | | | \$ 80 | | |
| Frequency* (in months) | | | | | | | | | |
| Examination | 12 | | | 12 | | | 12 | | |
| Lenses or Contact Lenses | 12 | | | 12 | | | 12 | | |
| Frame | 24 | | | 24 | | | 24 | | |
| Copayments: | | | | | | | | | |
| Exams | \$ 10 | \$ 10 | \$ 20 | \$ 10 | \$ 10 | \$ 20 | \$ 10 | \$ 10 | \$ 20 |
| Lenses | \$ 10 | \$ 25 | \$ 20 | \$ 10 | \$ 25 | \$ 20 | \$ 10 | \$ 25 | \$ 20 |

VOLUNTARY - Employer contributes 0% – 49% of total premium

Choose Your Option: 1 2 3 4 5 6 7 8 9

MONTHLY RATES:

3-Tier

| | | | | | | | | | |
|--------------------------|----------|----------|----------|----------|----------|----------|----------|----------|----------|
| Employee Only | \$ 7.24 | \$ 6.58 | \$ 6.19 | \$ 6.51 | \$ 5.89 | \$ 5.51 | \$ 6.07 | \$ 5.44 | \$ 5.08 |
| Employee + One Dependent | \$ 12.42 | \$ 11.29 | \$ 10.61 | \$ 11.18 | \$ 10.10 | \$ 9.46 | \$ 10.42 | \$ 9.34 | \$ 8.72 |
| Family | \$ 22.22 | \$ 20.20 | \$ 18.99 | \$ 20.00 | \$ 18.08 | \$ 16.92 | \$ 18.63 | \$ 16.72 | \$ 15.60 |

4-Tier

| | | | | | | | | | |
|---|----------|----------|----------|----------|----------|----------|----------|----------|----------|
| Employee Only | \$ 7.24 | \$ 6.58 | \$ 6.19 | \$ 6.51 | \$ 5.89 | \$ 5.51 | \$ 6.07 | \$ 5.44 | \$ 5.08 |
| Employee & Spouse / Civil Union Partner | \$ 14.13 | \$ 12.85 | \$ 12.08 | \$ 12.72 | \$ 11.50 | \$ 10.76 | \$ 11.85 | \$ 10.63 | \$ 9.92 |
| Employee & Dependents | \$ 13.70 | \$ 12.46 | \$ 11.71 | \$ 12.33 | \$ 11.15 | \$ 10.43 | \$ 11.49 | \$ 10.31 | \$ 9.62 |
| Family | \$ 21.41 | \$ 19.47 | \$ 18.30 | \$ 19.27 | \$ 17.42 | \$ 16.30 | \$ 17.96 | \$ 16.11 | \$ 15.04 |

NON-VOLUNTARY - Employer contributes 50% – 100% of total premium

Choose Your Option: 1 2 3 4 5 6 7 8 9

MONTHLY RATES:

3-Tier

| | | | | | | | | | |
|--------------------------|----------|----------|----------|----------|----------|----------|----------|----------|----------|
| Employee Only | \$ 4.75 | \$ 4.24 | \$ 4.00 | \$ 4.28 | \$ 3.80 | \$ 3.55 | \$ 3.98 | \$ 3.54 | \$ 3.27 |
| Employee + One Dependent | \$ 8.16 | \$ 7.28 | \$ 6.86 | \$ 7.34 | \$ 6.52 | \$ 6.10 | \$ 6.83 | \$ 6.07 | \$ 5.62 |
| Family | \$ 14.59 | \$ 13.03 | \$ 12.27 | \$ 13.13 | \$ 11.67 | \$ 10.91 | \$ 12.22 | \$ 10.86 | \$ 10.05 |

4-Tier

| | | | | | | | | | |
|---|----------|----------|----------|----------|----------|----------|----------|----------|---------|
| Employee Only | \$ 4.75 | \$ 4.24 | \$ 4.00 | \$ 4.28 | \$ 3.80 | \$ 3.55 | \$ 3.98 | \$ 3.54 | \$ 3.27 |
| Employee & Spouse / Civil Union Partner | \$ 9.28 | \$ 8.29 | \$ 7.80 | \$ 8.35 | \$ 7.42 | \$ 6.94 | \$ 7.77 | \$ 6.91 | \$ 6.39 |
| Employee & Dependents | \$ 9.00 | \$ 8.04 | \$ 7.57 | \$ 8.10 | \$ 7.19 | \$ 6.73 | \$ 7.54 | \$ 6.70 | \$ 6.20 |
| Family | \$ 14.06 | \$ 12.56 | \$ 11.83 | \$ 12.65 | \$ 11.24 | \$ 10.51 | \$ 11.78 | \$ 10.46 | \$ 9.68 |

ELIGIBILITY (PROBATIONARY) PERIOD FOR NEWLY HIRED EMPLOYEES

Coverage for newly hired employees is effective on the first day of the month following:

Other (explain):

CENSUS AND BILLING INFORMATION

| Number of Membership Types: | | | Monthly Rate | = | Total Premium | Billing Method |
|---|----------------------|---|-------------------------|-----------------------------------|-------------------------|--|
| Employee (3-Tier): | <input type="text"/> | X | \$ <input type="text"/> | = | \$ <input type="text"/> | <input type="checkbox"/> Monthly Invoice <input type="checkbox"/> Monthly Electronic Funds Transfer (EFT) If electing EFT, a completed Payment Option Form must be included with this application. |
| Employee (4-Tier): | <input type="text"/> | X | \$ <input type="text"/> | = | \$ <input type="text"/> | |
| Employee/Spouse or Civil Union Partner* | <input type="text"/> | X | \$ <input type="text"/> | = | \$ <input type="text"/> | |
| Employee/Dependent: | <input type="text"/> | X | \$ <input type="text"/> | = | \$ <input type="text"/> | |
| Employee/Dependents: | <input type="text"/> | X | \$ <input type="text"/> | = | \$ <input type="text"/> | |
| Family (3-Tier): | <input type="text"/> | | \$ <input type="text"/> | = | \$ <input type="text"/> | |
| Family (4-Tier): | <input type="text"/> | | \$ <input type="text"/> | = | \$ <input type="text"/> | |
| Total Number of Employees: | <input type="text"/> | | | | | |
| Rate Guarantee (No. of Months) _____ | | | | Include First Monthly Payment of: | \$ <input type="text"/> | |

*Civil Union Partner where applicable

PRODUCER INFORMATION

| | | | |
|------------------------------|-----------|-----------------|---|
| Producer Name: | | Agency Name: | |
| Street Address: | | Tax ID #: | |
| City: | | Commissions To: | <input type="checkbox"/> Producer <input type="checkbox"/> Agency |
| State: | ZIP Code: | Contracts To: | <input type="checkbox"/> Producer <input type="checkbox"/> Group |
| E-mail Address: | | Renewals To: | <input type="checkbox"/> Producer <input type="checkbox"/> Group |
| Telephone: () | | Fax: () | |
| Producer Signature: X | | | |

ADDITIONAL PROVISIONS

| |
|--|
| |
| |
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| |
| |

As a duly authorized officer/partner/proprietor of the Applicant, I apply for the vision plan outlined above. The undersigned represents that the Applicant is a legitimate group headquartered in the State of New Hampshire. This Application shall become part of the Group Contract for Vision Benefits ("Agreement") and by execution of this Application, the undersigned binds the Applicant to all of the terms of the Agreement. The Agreement shall become effective on the date referenced above (the "Effective Date"), provided Northeast Delta Dental accepts this Application. Statements in this Application are representations of the Applicant and any misrepresentations will cause the Agreement, if issued, to be voidable, at the sole option of Northeast Delta Dental. Payment of claims and determination of eligibility are contingent upon completion of this Application by the Applicant and acceptance by Northeast Delta Dental, issuance of the Agreement by Northeast Delta Dental, and receipt by Northeast Delta Dental of the first payment. On behalf of the Applicant, I understand the producer, if any, will be involved in the delivery and receipt of information relating to this Application and the Agreement. I acknowledge that said producer does not have authority to approve or change this Application or the Agreement, or to waive any of its provisions.

The policy provides vision benefits only. Review your policy carefully.

Name of Business/Group: _____

Red Tree Insurance Company, Inc.

By: **X** _____
(Duly Authorized Signature)

By: _____

Name (please print): _____

Name: **Thomas Raffio**

Title: _____

Title: **President & CEO**

Date: _____

Date: _____

DeltaVision is underwritten by Red Tree Insurance Company, Inc., a Northeast Delta Dental company. Claims processing, claims service and provider network administration for DeltaVision are provided, under contract, by EyeMed Vision Care, LLC and First American Administrators, Inc.

FOR DELTA DENTAL USE ONLY

| | | | |
|---------------|---------------------|------------------|------------------------------|
| Group Number: | Sublocation Number: | Division Number: | EyeMed Group Number: 9745514 |
|---------------|---------------------|------------------|------------------------------|