



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:	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
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MONTHLY RATES: RATES VALID TO JUNE 2012

<input type="checkbox"/> 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
<input type="checkbox"/> 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 & Child(ren)	\$ 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:	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
MONTHLY RATES: RATES VALID TO JUNE 2012									
<input type="checkbox"/> 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
<input type="checkbox"/> 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 & Child(ren)	\$ 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
Subscriber:	<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
Subscriber / Spouse or Civil Union Partner*	<input type="text"/>	X	\$ <input type="text"/>	=	\$ <input type="text"/>	
Subscriber / Child:	<input type="text"/>	X	\$ <input type="text"/>	=	\$ <input type="text"/>	
Subscriber / Children:	<input type="text"/>	X	\$ <input type="text"/>	=	\$ <input type="text"/>	
Family:	<input type="text"/>	X	\$ <input type="text"/>	=	\$ <input type="text"/>	
Total Number of Employees:	<input type="text"/>				Include First Monthly Payment of: \$ <input type="text"/>	
Rate Guarantee (No. of Months)	<input type="text"/>					*Civil Union Partnership 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

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 Maine. 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. **It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.**

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

Name of Business/Group: _____	Red Tree Insurance Company, Inc.
By: X _____ <small>(Duly Authorized Signature)</small>	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
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