

SERFF Tracking Number: DDAR-127287471 State: Arkansas
Filing Company: Delta Dental of Arkansas State Tracking Number: 49104
Company Tracking Number: VIS-ENR-11
TOI: H2OG Group Health - Vision Sub-TOI: H2OG.000 Health - Vision
Product Name: VIS-ENR-11
Project Name/Number: VIS-ENR-11/

Filing at a Glance

Company: Delta Dental of Arkansas

Product Name: VIS-ENR-11

TOI: H2OG Group Health - Vision

Sub-TOI: H2OG.000 Health - Vision

Filing Type: Form

SERFF Tr Num: DDAR-127287471 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 49104

Co Tr Num: VIS-ENR-11

State Status: Approved-Closed

Author: Sara Farris

Reviewer(s): Rosalind Minor

Date Submitted: 06/22/2011

Disposition Date: 06/30/2011

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: VIS-ENR-11

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer, Association

Filing Status Changed: 06/30/2011

State Status Changed: 06/30/2011

Created By: Sara Farris

Corresponding Filing Tracking Number:

Filing Description:

This is an enrollment form for groups that only purchased vision coverage.

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Sara Farris

Company and Contact

Filing Contact Information

Sara Farris,

1513 Country Club

Sherwood, AR 72120

sfarris@ddpar.com

501-992-1662 [Phone]

501-992-1663 [FAX]

Filing Company Information

<i>SERFF Tracking Number:</i>	<i>DDAR-127287471</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Delta Dental of Arkansas</i>	<i>State Tracking Number:</i>	<i>49104</i>
<i>Company Tracking Number:</i>	<i>VIS-ENR-11</i>		
<i>TOI:</i>	<i>H20G Group Health - Vision</i>	<i>Sub-TOI:</i>	<i>H20G.000 Health - Vision</i>
<i>Product Name:</i>	<i>VIS-ENR-11</i>		
<i>Project Name/Number:</i>	<i>VIS-ENR-11/</i>		
Delta Dental of Arkansas	CoCode: 47155	State of Domicile: Arkansas	
1513 Country Club Rd.	Group Code:	Company Type:	
Sherwood, AR 72120	Group Name:	State ID Number:	
(501) 992-1662 ext. [Phone]	FEIN Number: 71-0561140		

Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Delta Dental of Arkansas	\$50.00	06/22/2011	48986808

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/30/2011	06/30/2011

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Disposition

Disposition Date: 06/30/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	VIS-ENR-11	Approved-Closed	Yes

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Form Schedule

Lead Form Number: VIS-ENR-11

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 06/30/2011	VIS-ENR- 11	Application/ Enrollment Form	VIS-ENR-11	Initial			VIS-ENR- 11.pdf

VISION ENROLLMENT/CHANGE FORM

Delta Dental of Arkansas
 P.O. Box 15965
 Little Rock, AR 72231
 E-mail: eligibility@ddpar.com

- New Enrollment Status Change Address Change
 Termination Cobra

Effective Date			Group Number: _____			Social Security Number		
Month	Day	Year	Group Name: _____					
						Subscriber's Identifier (if applicable)		

LAST NAME: _____ FIRST: _____ MI: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL ADDRESS: _____

Date of Birth Marital Status Sex Date of Hire
 Single Male
 Married Female MM / DD / YY

1. COVERAGE CHANGES

* Please check the box(es) next to the reason(s) for your change

Type coverage selected (choose one)

- Employee
- Employee/Spouse
- Employee/Child
- Employee/Children
- Employee/Family

- Add Dependent(s) **listed below**
- Remove Dependent(s) **listed below**
- Name Change
- Late Entrance (employee)
- Reason(s) for Change:
- Marriage
- Divorce
- Birth or adoption of child
- Full Time Student
- Handicapped
- Other _____
- COBRA effective date _____

- Change Coverage
- Address Change only
- Qualifying event
- Late Entrance (dependent)
- Date of event _____
- Loss of spouse's coverage
- No longer dependent child
- Death of dependent
- No longer Full Time Student

Other Coverage Info:
 Do you have current vision coverage? Yes No
 Is this coverage intended to replace your current vision coverage? Yes No

2. LIST ALL MEMBERS TO BE ENROLLED OR AFFECTED BY CHANGE

Add	Remove	Last (if different)	First	MI	Relationship	Sex M/F	Birthdate (MM/DD/YY)
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						

3. AUTHORIZATION

I authorize eye health care professionals, eye health care office personnel, and other health care professionals and entities to disclose to Delta Dental of Arkansas, its agents and employees (including, without limitation, its claims and customer service personnel) all information necessary to determine (1) eligibility for coverage and (2) covered benefits. This authorization is made for each individual to be enrolled or affected by this change. The authorization is valid for 30 months from the date this form is signed for the purpose of collecting information in connection with enrollment, coverage reinstatement, or requests to change benefits. The authorization is valid for the term of coverage for the purpose of collecting information in connection with claims for benefits. The applicant or the applicant's authorized representative is entitled to receive a copy of the authorization form.

4. CERTIFICATION

I certify that the information supplied by me on this form is accurate to the best of my knowledge. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

- I have been offered the opportunity to enroll in the vision program through Delta Dental; however, **I waive coverage at this time.**
- I authorize payroll deductions.

Signature: _____ Date: _____

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Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	06/30/2011
Bypass Reason:	This is an enrollment form not subject to these requirements.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	06/30/2011
Bypass Reason:	This is an enrollment form not subject to this requirements.		
Comments:			