DELTA DENTAL®

STRYDEN, Inc. | DeltaVision In partnership with VSP®

Small Group Enrollment Application

(New Enrollment/Changes to Enrollment)

Delta Dental of Virginia | DeltaVision
Underwritten by Stryden, Inc.
4818 Starkey Road, Roanoke, VA 24018
(540) 989-8000 · (800) 237-6060
Fax: (540) 776-8109

IMPORTANT: Enrollment Application with incomplete or missing information will be returned)

THIS SECTION TO BE COMPLETED BY GROUP ADMINISTRATOR

Account Name:		**Effective Date:**
Account No:	**Dental Sub-Account No:**	**Dental Sub-Sub Account No:**
Vision Sub-Account No:		**Vision Sub-Sub Account No:**
Department:		**Dental Benefit Plan ID:**
Vision Benefit Plan ID:		

Employment Status (choose one):
☐ Active ☐ COBRA

Employee Type (choose one):
☐ Hourly ☐ Salaried ☐ Full-Time ☐ Part-Time

Section A: ENROLLMENT/CHANGE (For qualifying event provide {date and} reason)

☐ New Hire ☐ Change ☐ Open Enrollment ☐ Reinstatement ☐ Cancel Coverage ☐ COBRA (Effective Date ___/___/___)
Qualifying Event: ☐ ADD dependent, spouse, or domestic partner ☐ DROP/Terminate dependent, spouse, or domestic partner
☐ Name - Previous Name _____ ☐ Address ☐ Telephone ☐ Other _____
☐ Decline Coverage - I understand that I have been offered and have elected to decline coverage under my employer sponsored dental and/or vision plan with Delta Dental and/or Stryden, Inc. at this time. I will not be eligible to enroll until the next open enrollment period or in the event of a qualifying event.
(Sign, date and complete first line of Section B.) **Signature** _____ Date _____

Date of Qualifying Event:
_____/_____/_____

Reason(s) for Qualifying Event: ☐ Marriage ☐ Loss of other group coverage ☐ Divorce ☐ No longer dependent ☐ Birth or adoption ☐ Death of spouse/dependent
☐ Other _____

Section B: EMPLOYEE/SUBSCRIBER INFORMATION

Last Name	First Name	MI	Social Security Number - -	Group Assigned ID (if applicable)
Mailing Address (#, Street, Apt)		City	State	ZIP
Home Telephone ( )	Date of Birth / /	Gender ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married	Date of Hire _____/_____/_____
Personal Email Address	☐ I **do not** agree to receive communications regarding my group plan (such as plan amendments, EOB's and similar communications) via the email address I have supplied on this application. Please continue mailing those to me.			

Section C: DENTAL COVERAGE (Underwritten by Delta Dental of Virginia)

Product(check one)	**{Plan** (if applicable)	**Coverage Type (check one)**
☐ Delta Dental PPO Plus Premier™ ☐ Delta Dental PPO™ ☐ aXcess™ ☐ Delta Dental PPO™ — EPO Plan Design	☐ High Option ☐ Low Option	☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family

Section D: VISION COVERAGE (Underwritten by Stryden, Inc.)

Product(check one)	**Plan** (if applicable)	**Coverage Type (check one)**
☐ DeltaVision® — 130 ☐ DeltaVision® — 150 ☐ DeltaVision® — 150 Plus ☐ DeltaVision® — 150 Plus with EasyOptions	☐ High Option ☐ Low Option	☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family

Section E: LIST ALL MEMBERS TO BE ENROLLED{/DROPPED BASED ON THE COVERAGE TYPE SELECTED

	Last Name (if different)	First Name, MI	SSN	Relationship	Gender (M/F)	Date of Birth	Dental/Vision (circle)
☐ Add ☐ Drop							☐ Dental/Vision ☐
☐ Add ☐ Drop							☐ Dental/Vision ☐

☐ Add ☐ Drop							☐ Dental/Vision ☐
☐ Add ☐ Drop							☐ Dental/Vision ☐
☐ Add ☐ Drop							☐ Dental/Vision ☐

Section F: OTHER GROUP COVERAGE (COORDINATION OF BENEFITS)

Will you, your spouse, or any dependent children be covered under another group dental or vision plan while this policy is in effect: ☐ Yes ☐ No

If yes, are dependents covered? ☐ Yes ☐ No

Name of Carrier: _____ Group Number: _____

Street Address of Carrier: _____ City: _____ State: _____ Zip:_____

Name of Employer or Group this coverage is available from:

Section G: AUTHORIZATION AND CERTIFICATION

I authorize dentists, dental and vision office personnel, vision providers and other health care professionals and entities to disclose to Delta Dental of Virginia and/or Stryden, Inc., its agents and employees (including, without limitation, its claims and customer service personnel) all information necessary to determine eligibility for coverage. This authorization is made for each individual to be enrolled or affected by this change valid for 30 months from the date this form is signed. The applicant or the applicant's authorized representative is entitled to receive a copy of the authorization form.

I understand that my selection of coverage may be changed only during the open enrollment period of each year unless I experience a qualifying event listed under "Reasons for Qualifying Event" in Section A. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement may have violated state law. I certify that the information supplied by me on this form is accurate to the best of my knowledge.

Signature: _____ Date:_____

Your privacy is important to Delta Dental of Virginia and Stryden, Inc. We are committed to safeguarding your protected health information and are making every reasonable effort to ensure we maintain that information securely.

To learn more about how your dental or vision information may be used and disclosed, and how you can get access to this information, please visit our website at DeltaDentalVA.com/privacypractices.aspx; or, for vision, visit DeltaDentalVA.com/privacypractices.aspx. To request a printed copy of either privacy notice, contact us, with attention to: Privacy Unit, 4818 Starkey Road, Roanoke, VA 24018 or by calling 800-237-6060.

Delta Dental of Virginia and Stryden, Inc. Privacy Practices

Protecting the privacy and confidentiality of information about our customers is very important to Delta Dental of Virginia and Stryden, Inc. Accordingly, we strive to comply with each of the following practices.

Notice of Insurance Information Practices:

1. Personal information may be collected from persons other than an individual(s) proposed for coverage.
2. This information, as well as other personal or privileged information collected later, may, in certain circumstances, be disclosed to third parties without authorization.
3. You may access and correct all personal information that is collected.
4. You will be furnished a more complete explanation of our information practices upon request.

Notice of Financial Information Collection and Disclosure Practices:

1. Financial information collected or received in connection with an insurance transaction may, in certain circumstances, be disclosed to non-affiliated third parties.
2. The individual to whom the financial information pertains may direct that it not be disclosed except as permitted or required by law.
3. This right may be exercised at any time and remains in effect until the individual revokes it.
4. To direct that your financial information not be disclosed except as permitted or required by law, you may send a signed letter to that effect to us at the following address:

Benefit Services
Attn: Privacy Coordinator
4818 Starkey Road
Roanoke, Virginia 24018

5. A non-affiliated third party to whom financial information is disclosed may disclose it to any other person if disclosure would be permitted by Virginia Code Section 38.2-613.
6. We will furnish you a more complete explanation of our financial information collection and disclosure practices upon request. To receive a copy of this explanation, please (a) contact us at the address in paragraph 3 of this notice or (b) call us at 1-800-237-6060.

DeltaVision® is underwritten by Stryden, Inc., an affiliate of Delta Dental of Virginia. Claims processing, claims service and provider network administration for DeltaVision® are provided under contract by VSP.