DELTA DENTAL®

Group Enrollment Application
(New Enrollment/Changes to Enrollment)

Delta Dental of Virginia
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:	**Sub-Account No:**	**Sub-Sub Account No:**
Department:		**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 in section D)

☐ New Hire ☐ Open Enrollment ☐ Reinstatement ☐ Cancel Coverage ☐ COBRA (Effective Date ____/____/____)
Qualifying Event: ☐ ADD dependent, spouse, or domestic partner ☐ DROP 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 plan with Delta Dental 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 a dependent ☐ Birth or adoption ☐ Death of spouse/dependent ☐ Other _____

Section B: EMPLOYEE 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 / /	Number of Hours Worked Per Week

Email Address ☐ I agree to receive communications regarding my group plan via the email address I have supplied on this application.

Section C: COVERAGE

Product (check one) ☐ Delta Dental PPO plus Premier™ ☐ Delta Dental PPO™ ☐ aXcess™ ☐ Delta Dental PPO™ – EPO Plan Design	**Plan** (if applicable) ☐ High Option ☐ Low Option	**Coverage Type (check one)** ☐ Employee ☐ Employee + Spouse ☐ Employee + Child ☐ Employee + Children ☐ Employee + Family ☐ Employee + Domestic Partner (if offered under your dental plan)

Section D: 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 (MM/DD/YYYY)
☐ Add ☐ Drop						
☐ Add ☐ Drop						
☐ Add ☐ Drop						
☐ Add ☐ Drop						

Section E: OTHER GROUP COVERAGE (COORDINATION OF BENEFITS)

Will you, your spouse, or domestic partner, or any dependent child be covered under any other group 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 E: AUTHORIZATION AND CERTIFICATION

I authorize dentists, dental office personnel, and other health care professionals and entities to disclose to Delta Dental of Virginia, 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 underwriting purposes. 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.

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. 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 information may be used and disclosed, and how you can get access to this information, please visit our website at deltadentalva.com/privacypractices.aspx. To request a printed copy of the privacy notice, contact us at Delta Dental of Virginia, attention: Privacy Unit, 4818 Starkey Road, Roanoke, VA 24018 or by calling 800-234-6060.

Delta Dental of Virginia Privacy Practices

Protecting the privacy and confidentiality of information about our customers is very important to Delta Dental of Virginia. 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 provided by Virginia Code Section 38.2-613.
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 provided by Virginia Code Section 38.2-613, you may send a signed letter to that effect to us at the following address:

Delta Dental of Virginia
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 4 of this notice or (b) call us at 1-800-237-6060.