



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: Incomplete information will delay enrollment. Please print using a ball point pen, press firmly and print clearly.

| | |
|--------------------|------------------------|
| Group Name: | Effective Date: |
|--------------------|------------------------|

| | |
|------------------|---------------------------------|
| Group No: | Sublocation/Division No: |
|------------------|---------------------------------|

Section A: ENROLLMENT/CHANGE (For qualifying event provide date and reason in section D)

New Hire ADD dependent/spouse Coverage Change Reinstatement
 Open Enrollment DROP dependent/spouse COBRA (Effective Date ___/___/___) Cancel Coverage
 Change/Update Information 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 during the coverage period.
 (Sign, date and complete first line of Section B.) **Signature** _____ **Date** _____

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 <input type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married | If married, will your spouse or dependents have coverage under another group dental plan on the date this plan becomes effective? <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Email Address | | | <input type="checkbox"/> I agree to receive communications regarding my group plan via the email address I have supplied on this application. | |
| Date of Hire / / | Number of Hours Worked Per Week | Payroll Status | | |

Section C: COVERAGE

| | | |
|---|--|---|
| Product (check one) <input type="checkbox"/> Delta Dental PPO plus Premier <input type="checkbox"/> DeltaCare® <input type="checkbox"/> Delta Dental PPO SM <input type="checkbox"/> Delta Dental PPO – EPN <input type="checkbox"/> Delta Dental Premier® | Plan (if applicable) <input type="checkbox"/> High Option <input type="checkbox"/> Low Option | Coverage Type (check one) <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Employee/Family <input type="checkbox"/> Employee/Domestic Partner (if offered under your dental plan) |
|---|--|---|

Section D: LIST ALL MEMBERS TO BE ENROLLED

| | Last Name (if different) | First Name, MI | Relationship | Sex (M/F) | Date of Birth (MM/DD/YYYY) | DELTACARE ONLY | |
|---|--------------------------|----------------|--------------|-----------|----------------------------|---------------------------|-----------|
| | | | | | | Dentist (First/Last Name) | Provider# |
| <input type="checkbox"/> Add <input type="checkbox"/> Drop | | | | | | | |
| <input type="checkbox"/> Add <input type="checkbox"/> Drop | | | | | | | |
| <input type="checkbox"/> Add <input type="checkbox"/> Drop | | | | | | | |
| <input type="checkbox"/> Add <input type="checkbox"/> Drop | | | | | | | |

| | |
|--|---|
| Date of Qualifying Event / / | Reason(s) for Qualifying Event <input type="checkbox"/> Marriage <input type="checkbox"/> Loss of other group coverage <input type="checkbox"/> Divorce <input type="checkbox"/> No longer dependent <input type="checkbox"/> Birth or adoption <input type="checkbox"/> Death of spouse/dependent <input type="checkbox"/> Other _____ |
|--|---|

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 Change" in Section D. 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. Under DeltaCare, in the event you fail to select a dentist in the DeltaCare network, you hereby authorize Delta Dental to select a dentist on your behalf so that your enrollment may be complete. You also authorize Delta Dental to change your selection, if you select a dentist not in Delta Dental of Virginia DeltaCare network or your dentist no longer participates with the Delta Dental of Virginia DeltaCare network.

Signature: _____ Date: _____