

# Small Group Enrollment Application

(New Enrollment/Changes to Enrollment)

## Delta Dental of Virginia | Delta Vision Underwritten by Stryden, Inc.

4818 Starkey Road, Roanoke, VA 24018 (540) 989-8000 (800) 237-6060 Fax: (540) 776-8109

STRYDEN, Inc. Delta Vision

IMPORTA	NT: Enrollment A	Application	with inc	comple	ete or n	nissing in	forma	tion v	vili be	returnea	)					
THIS SEC	TION TO BE CON	MPLETED E	BY GRO	UP AD	MINIST	RATOR										
Account Name:  Account No:  Dental Sub-Account No:							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 (choos						☐ Part-	Time			
Section A	A: ENROLLMENT/	CHANGE (	(For qua	lifying	event p	orovide {c	date a	nd} re	eason)							
Qualifying Name Declin and/or vi the event	lire  Change  ADO of Event:  ADO of Event:  ADO of Events Name of	dependent, derstand th ta Dental a rent.	, spouse nat I have nd/or St	, or do e been tryden,	omestic offerec , Inc. at	partner [ Addid and have this time.	DRO ress e elec . I will	OP/Te L ted to not b	ermina Telepl decli e eligi	te depend none [ ne covera ble to enr	dent, spou Other _ ge under r oll until the	se, or don	yer spo en enro	nsor Ilme	red dental	
Date of C	Qualifying Event:										oup cover	age 🗌 Di	vorce [	No	longer	
dependent Birth or adoption Death of spouse/dependent Other																
	B: EMPLOYEE/SU	BSCRIBER														
Last Nam	ie		Firs	t Name	е			MI	Social Security Number			Grou	Group Assigned ID (if applicable)			
Mailing A	ddress (#, Street,	Apt)						City	St			State		ZIP		
			Gender Male			Marital Status  Single			Date of Hire							
( )	)	/	/		Male Fema	ile			Marrie							
Personal	Email Address			amei	ndment	s, EOB's a	and si	milar (	comm						plan supplied on this	
Section C	: DENTAL COVE	RAGE (Und	derwritt						ing th	000 10 1110						
Product(check one)				<b>{Plan</b> (if applicable)				Coverage Type (check one)								
☐ Delta Dental PPO Plus Premier™ ☐ Delta Dental PPO™				☐ High Option					☐ Employee ☐ Employee + Spouse							
aXcess	s™ Dental PPO™ — El	PO Plan De	sign		Lov	w Option					oyee + Ch oyee + Fai					
Section F	)· VISION COVER	AGE (Unde	erwritte	n by S	tryden	Inc.)										
Section D: VISION COVERAGE (Underwritten by S  Product(check one)				Plan (if applicable)				Coverage Type (check one)								
☐ DeltaVision® — 130																
☐ DeltaVision® — 150				☐ High Option☐ Low Option					Empl	☐ Employee ☐ Employee + Spouse						
	DeltaVision® — 150 Plus  DeltaVision® — 150 Plus with EasyOptions  DeltaVision® — 150 Plus with EasyOptions  DeltaVision® — 150 Plus with EasyOptions															
Section E	E: LIST ALL MEME	BERS TO BI	E ENRO	LLED{	/DROP	PPED BAS	SED O	N TH	E CO\	/ERAGE 1	YPE SELE	CTED				
	Last Name (if o	different)	First N	Name,	MI	s	SSN		Rela	tionship	Gender (M/F)	Date of	Birth	[	Dental/Vision (circle)	
☐ Add ☐ Drop															Dental/Vision □	
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Add			□ Dental /\/ision □					
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Add			☐ Dental/Vision ☐					
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Add			☐ Dental/Vision ☐					
☐ Drop			L Dentaly Vision L					
Section F: OTHER GROUP COVERAGE (COORDINATION	ON 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:								
Street Address of Carrier:	City:	State:	:e: Zip:					
Name of Employer or Group this coverage is available fr								
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.