DeltaVision®

Underwritten by Stryden, Inc. and administered by VSP
Small Group Vision Insurance Application
For groups with 2-300 employees

4818 Starkey Road • Roanoke, VA 24018 • 888.335.8216 • DeltaVisionVA.com

Application Instructions

Step 1: Complete **Sections 1 and 3** for all groups.
Step 2: Complete the appropriate section (**Sections 4 and 5)** for the plans being offered.
Step 3: Complete **Sections 6 and 7** for all groups. **Group administrator must sign and date.**
Step 4: Complete **Section 8** (if applicable) with agent information. **Agent must sign and date.**

REQUESTED EFFECTIVE DATE: __/__/__ CONTRACT PERIOD: __/__/__ to __/__/__

SECTION 1: Group Information (Please print clearly, using black ink.)

Group Name			Group Number(Internal Use Only)
Physical Address	City	State	ZIP
Mailing Address (if different from physical address)	City	State	ZIP
Group Administrator ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.	Email Address	Telephone ( )	Fax ( )
.			
Billing Contact (Primary)	Email Address	Telephone ( )	Fax ( )
Billing Contact (Secondary)	Email Address	Telephone ( )	Fax ( )
Billing Address	City	State	ZIP
Nature of Business	EIN/TIN#	NAICS Code	

Print group correspondence/reports with: ☐ Complete Social Security Number (SSN) ☐ Alternate Identification Number (other than SSN)*
* If Alternate Identification Number is checked above, the number will be assigned by: ☐ Group ☐ Stryden, Inc.(DeltaVision)

SECTION 2: Monthly Rates & Employer Contribution

DeltaVision 130, DeltaVision 150, DeltaVision 150 Plus, DeltaVision 150 Plus with EasyOptions Rates:

*Employee $*_____ *Emp/Spouse $*_____ *Emp/Child(ren) $*_____ *Emp/Family $*_____

High Option Rates:

*Employee $*_____ *Emp/Spouse $*_____ *Emp/Child(ren) $*_____ *Emp/Family $*_____

Employer Contribution: To Employee Rate _____**%** To Dependent Rate_____**%**

SECTION 3: Eligibility Information

All eligible employees (and dependents) who are employed by the Group on the inception date of the plan are immediately eligible for coverage. Each present or new employee is an "eligible employee" if he or she (1) works a minimum of 20hours per week; (2) is certified as being eligible by the Group; (3) receives compensation from the Group; and (4) is a member of the group as specified in the Group Vision Contract.

Total Employees	Employees Ineligible for Benefits (-)	Covered by Other Insurance (-)	Total Eligible Employees (=)	Total Eligible Employees Enrolled

New Hire Waiting Period: The length of time future employees must be employed before becoming eligible for coverage under the vision plan:
☐ 1st of the month following 90 days
☐ Match Medical: ☐ Date of Hire ☐ _____days ☐ Other _____
Following any applicable new hire waiting period, coverage becomes effective: ☐ 1st of the month ☐ Exact Date

When Coverage Ends: At the time of termination (except for over age dependent), coverage ends:
☐ Last Day of Month ☐ Match Medical - Exact Date ☐ Other _____

Domestic Partner Coverage: ☐ Yes ☐ No If yes, is coverage extended to children of domestic partner: ☐ Yes ☐ No

SECTION 4: Employer Paid & Voluntary Plans 2 – 300 employees)	
DeltaVision 130 - ☐ (check here to select plan)	
WellVision Exam	$10
Prescription Glasses	$25
Frame OR Contact Allowance	$130
Frequency of Service	12 month exam/12 month lens/24 month frame
Funding Type	☐ Contributory ☐ Voluntary
DeltaVision 150 - ☐ (check here to select plan)	
WellVision Exam	$10
Prescription Glasses	$25
Frame OR Contact Allowance	$150
Frequency of Service	12 month exam/12 month lens/24 month frame
Funding Type	☐ Contributory ☐ Voluntary
DeltaVision 150 Plus – ☐ (check here to select plan) **OR** ☐(check here to make this plan the high option)	
WellVision Exam	$10
Prescription Glasses	$20
Frame OR Contact Allowance	$150
Frequency of Service	12 month exam/12 month lens/12 month frame
Funding Type	☐ Contributory ☐ Voluntary
DeltaVision 150 Plus with EasyOptions - ☐ (check here to select plan) **OR** ☐(check here to make this plan the high option)	
WellVision Exam	$10
Prescription Glasses	$20
Frame OR Contact Allowance	$150
Frequency of Service	12 month exam/12 month lens/12 month frame
EasyOptions	Choice of one of the following at the time of service: $250 frame allowance, anti-reflective lenses, progressive lenses, photochromic lenses, or $200 contact lens allowance (instead of glasses)
Funding Type	☐ Contributory ☐ Voluntary

SECTION 5: Benefit Options	
KidsCare for dependents under age - ☐ (check here to **add** KidsCare to plan(s) already selected above)	
Suncare Enhancement - ☐ (check here to **add** Suncare Enhancement to plan(s) already selected above)	
Frame Allowance	Apply to non-prescription sunglasses. Refer to Schedule of Benefits for Frame Allowance.

SECTION 6: Website Authorization

The individual(s) identified below is/are authorized to access the Stryden, Inc. website and perform the function(s) checked.

First and Last Name of User:	Email Address:
	Telephone: ( )

Security Question: Security Answer:

☐ Submit, modify and view enrollment data and print subscriber ID cards ☐ Access monthly bill

First and Last Name of User:	Email Address:
	Telephone: ( )

Security Question: Security Answer:

☐ Submit, modify and view enrollment data and print subscriber ID cards ☐ Access monthly bill

(1) Stryden, Inc. may rely on electronically submitted enrollment data to the same extent as if submitted by non-electronic means;
(2) Group will undertake reasonable measures to safeguard account information, including username and password, and to prevent unauthorized access to the website by someone acting or purporting to act on the Group's behalf. Further, it is the Group's responsibility to inform and educate any authorized representative of his/her obligations under state or federal privacy and security laws;
(3) All requests to close the Website Account must be submitted via email at mktgadmin@deltadentalva.com or fax to 540-774-7574. Such requests shall be processed within three business days (excluding holidays);
(4) Group shall be solely responsible for any liability arising from the use of the Website Account and shall indemnify, hold harmless and defend Stryden, Inc. and VSP against any claim arising from the Authorized User's use of the Website Account, or the Group's failure to safeguard account information, including, but not limited to, errors and omissions and violations of state and federal privacy laws.

SECTION 7: Group Administrator Signature

The undersigned represents and warrants that he or she is authorized to sign on the Group's behalf. All of the information contained in this application is true and correct to the best of his or her knowledge. By signing below, the Group, acting through its authorized Group Administrator, acknowledges and agrees that it will be bound by the terms and conditions of Stryden, Inc.'s group contract.

Print Name:	
Signature:	Date:
(Office / Owner or Group Administrator's Signature Required)	
Title:	

SECTION 8: Agent Information (if applicable)

Agent's Name (PLEASE PRINT):	
Agent's License Number or SSN:	Currently appointed with Stryden, Inc.? ☐ Yes ☐ No
Commission Payable to (check one) ☐ Agent ☐ Agency	If payable to Agency, list name of Agency
Agency TIN#:	Agency currently appointed with Stryden, Inc.? ☐ Yes ☐ No
Agent Signature:	Date:

TO AVOID PROCESSING DELAYS, PLEASE MAKE SURE YOU:

- ☐ Include most recent required tax and wage documentation (refer to www.deltadentalva.com/deltavision or the 2020 broker version of the small group brochure for more details.
- ☐ Include employee enrollment forms.
- ☐ Include a check for the first month's premium.

STRYDEN, INC. USE ONLY:	