Delta Dental of Virginia
DeltaVision Underwritten by Stryden, Inc.
Small Group Combined Insurance Application
4818 Starkey Road • Roanoke, VA 24018 • 888.335.8216

Application Instructions

Step 1: Complete **Sections 1 to 3** for all groups.
Step 2: Complete the appropriate section (**Sections 4 thru 7)** for the plans being offered.
Step 3: If DeltaVision coverage is desired, complete **Sections 8 and 9.**
Step 4: Complete **Sections 10 and 11** for all groups. **Group administrator must sign and date.**
Step 5: Complete **Section 12** (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 ID cards with: ☐ Masked Social Security Number (SSN) ☐ Assigned/Alternate ID Number (other than SSN)*
Print group correspondence/reports with: ☐ Complete Social Security Number (SSN) ☐ Alternate ID Number (other than SSN)*
* If Alternate Identification Number is checked, the number will be assigned by: ☐ Group ☐ Delta Dental of Virginia/Stryden Inc (DeltaVision)

SECTION 2: Monthly Rates & Employer Contribution

Dental plans underwritten by Delta Dental of Virginia

Delta Dental PPO™ or Delta Dental PPO plus Premier™ Rates:

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

Delta Dental PPO™ - EPO Plan Design or low option rates (if applicable):

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

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

Vision plans underwritten by Stryden, Inc.

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

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

DeltaVision high option rates:

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

Employer Vision 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 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 dental or 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

DENTAL COVERAGE (underwritten by Delta Dental of Virginia)

SECTION 4: Employer Paid Traditional Plans (2 – 49 employees)

aXcess™ – Available as a single option plan only

Benefit Options	*Check one* ☐ 100/80/25/25 ☐ 100/80/50/0
Lifetime Deductible	$50
Annual Maximum& Lifetime Ortho Maximum	$2,000/$500
Major (Type III)	No Benefit Waiting Period
Ortho (Type IV)	No Benefit Waiting Period

SECTION 5: Employer Paid Traditional Plans (5 – 99 employees)

Benefit Options	Delta Dental PPO Plus Premier™:	☐ 100/80/50/50 Passive ☐ 100/100 90/80 60/50 50/50 Active-Option 1 ☐ 100/90 80/70 50/50 50/50 Active-Option 2
	Delta Dental PPO™:	☐ 100/80/50/50 Passive ☐ 100/80 90/70 60/50 50/50 Active

Plan Options

Check one	☐ Single Option	1) Complete the Single Option column.
	☐ High/Low Option	1) Complete both the High and Low Option columns.
	☐ Delta Dental PPO™ – EPO Plan Design	1) Complete the High Option column. 2) Complete Section 7

	Single Option or High Option	Low Option*
Annual Deductible *(Check one)*	☐ $0 ☐ $25 ☐ $50	☐ $0 ☐ $25 ☐ $50
Annual Maximum & Lifetime Ortho Maximum *(If applicable) (Check one)*	☐ $1000/$1000 ☐ $1250/$1250 ☐ $1500/$1500 ☐ $2000/$2000 ☐ $2500/$2500 ☐ $5000/$2500	☐ $1000 ☐ $1250 ☐ $1500 ☐ $2000 ☐ $2500 ☐ $5000
Diagnostic/ Preventive & Basic Care (Type I & II)	Composite fillings on all teeth ☐ Yes ☐ No Endodontics/Periodontics/Oral Surgery* ☐ Type II OR ☐ Move to Type III	
Majors (Type III) *(Type I & II required) Indicate if covered and benefit waiting period.*	☐ Yes ☐ No ☐ None ☐ 6 months ☐ 12 months	☐ Yes ☐ No ☐ None ☐ 6 months ☐ 12 months
Ortho (Type IV) ** *(Type I-III required) Indicate if covered and benefit waiting period.*	☐ Yes ☐ No ☐ None ☐ 6 months ☐ 12 months	

SECTION 6: Voluntary Traditional Plans (5-300 enrolled employees)

Benefit Options	Delta Dental PPO Plus Premier™:	☐ 100/80/50/50 Passive ☐ 100/100 90/80 60/50 50/50 Active-Option 1 ☐ 100/90 80/70 50/50 50/50 Active-Option 2
	Delta Dental PPO™:	☐ 100/80/50/50 Passive ☐ 100/80 90/70 60/50 50/50 Active

Plan Options			
Check one	☐ Single Option ☐ High/Low Option ☐ Delta Dental PPO™ – EPO Plan Design	1) Complete the Single Option column. 1) Complete both the High and Low Option columns. 1) Complete the High Option column. 2) Complete Section 7.	
		Single Option or High Option	**Low Option***
Annual Deductible *(Check one)*		☐ $25 ☐ $50	☐ $25 ☐ $50
Annual Maximum & Lifetime Ortho Maximum *(If applicable)* *(Check one)*		☐ $1000/$1000 ☐ $1250/$1250 ☐ $1500/$1500 ☐ $2000/$2000 ☐ $2500/$2500 ☐ $5000/$2500	☐ $1000 ☐ $1250 ☐ $1500 ☐ $2000 ☐ $2500 ☐ $5000
Diagnostic/ Preventive & Basic Care (Type I & II)	Composite fillings on all teeth Endodontics/Periodontics/Oral Surgery*	☐ Yes ☐ No ☐ Type II OR ☐ Move to Type III	
Majors (Type III) *(Type I & II required)* *Indicate if covered and benefit waiting period.*		☐ Yes ☐ No ☐ 6 months ☐ 12 months	☐ Yes ☐ No ☐ 6 months ☐ 12 months
Ortho (Type IV) ** *(Type I-III required)* *Indicate if covered and benefit waiting period.*		☐ Yes ☐ No ☐ 12 months	

SECTION 7: Delta Dental EPO™ – EPO Plan Design - Available as a single option plan or as the low option of a High/Low plan only.

Benefit Options *(Check one)*	☐ Plan CP140 ☐ Plan CP360
Annual Deductible	No Deductible
Annual Maximum & Lifetime Orthodontic Maximum	$2000/$2000 $3000/$2000
Major (Type III)	No Benefit Waiting Period
Ortho (Type IV)	No Benefit Waiting Period.

* If coverage is only for Type I and II benefits, and "Move to Type III" is selected, then Endodontics/Periodontics/Oral Surgery services **are not** covered benefits.

**In order for Type IV (orthodontic benefits) to be offered, a minimum of ten (10) employees must be enrolled.

VISION COVERAGE (Underwritten by Stryden, Inc.)	
SECTION 8: 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 9: Benefit Options	
KidsCare for dependents under age 26 - ☐ (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)	
Apply to non-prescription sunglasses. Refer to Schedule of Benefits for Frame Allowance.	

SECTION 10: Website Authorization

The individual(s) identified below is/are authorized to access Delta Dental of Virginia's (DDVA)and Stryden, Inc's (DeltaVision) 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) DDVA and/or 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.
(4) Group shall be solely responsible for any liability arising from the use of the Website Account and shall indemnify, hold harmless and defend DDVA and Stryden, Inc. 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 11: 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 the group contract(s).

Signature:	Date:
(Officer / Owner or Group Administrator's Signature Required)	
Title:	

SECTION 12: Agent Information (if applicable)

Agent's Name (PLEASE PRINT):

Agent's License Number or SSN:	Currently appointed with Delta Dental: ☐ Yes ☐ No 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 Delta Dental: ☐ Yes ☐ No Stryden, Inc.: ☐ Yes ☐ No
Agent Signature:	Date:

TO AVOID PROCESSING DELAYS, PLEASE MAKE SURE YOU:

- ☐ Include employee enrollment forms.
- ☐ Include a check for the first month's premium.
- ☐ If waiver of benefit waiting periods is requested; include prior carrier premium statements and benefit summary to document 12 months of prior coverage.

INTERNAL USE ONLY:

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.

NONDISCRIMINATION NOTICE

Delta Dental of Virginia and Stryden, Inc. comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sexual orientation. Delta Dental of Virginia and Stryden, Inc. do not exclude people or treat them differently because of race, color, national origin, age, disability or sexual orientation.

Delta Dental of Virginia and Stryden, Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Civil Rights Coordinator.

If you believe that Delta Dental of Virginia or Stryden, Inc. have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sexual orientation, you can file a grievance with:

Civil Rights Coordinator
ATTN: Compliance Dept.
4818 Starkey Road
Roanoke, VA 24018-8510
1-800-237-6060,
TTY number: 1-877-287-9039,
Fax: 540-491-9714
Compliance@corvesta.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
1–800–368–1019, 800–537–7697 (TDD)
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html

LANGUAGE ASSISTANCE SERVICES

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-237-6060 (TTY: 1-877-287-9039).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-237-6060 (TTY: 1-877-287-9039)번으로 전화해 주십시오.

The Benefits of Experience

4818 Starkey Road • Roanoke, VA 24018
888.335.8216
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