



**Small Group Enrollment Application**  
(New Enrollment/Changes to Enrollment)

**Underwritten by Stryden, Inc. and administered by VSP**  
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**

<b>Account Name:</b>		<b>Effective Date:</b>	
<b>Account No:</b>	<b>Sub-Account No:</b>	<b>Sub-Sub Account No:</b>	
<b>Department:</b>		<b>Benefit Plan ID:</b>	
<b>Employment Status (choose one)</b> <input type="checkbox"/> Active <input type="checkbox"/> COBRA		<b>Employee Type (choose one):</b> <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-time	

**Section A: ENROLLMENT/CHANGE (For qualifying event provide date and reason)**

New Hire    Open Enrollment    Reinstatement    Cancel Coverage    COBRA (Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_)

Qualifying Event:    ADD dependent, spouse, or domestic partner    DROP/Terminate 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 vision plan with Stryden, Inc. 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** \_\_\_\_\_

<b>Date of Qualifying Event</b> / /	<b>Reason(s) for Qualifying Event</b>		
	<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 or domestic partner/dependent
	<input type="checkbox"/> Other _____		

**Section B: EMPLOYEE/SUBSCRIBER 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	Date of Hire / /
Personal} Email Address		<input type="checkbox"/> I agree to receive communications regarding my group plan (such as plan amendments, EOB's and similar communications) via the email address I have supplied on this application.		

**Section C: COVERAGE**

<b>Product(check one)</b> <input type="checkbox"/> DeltaVision® 130 <input type="checkbox"/> DeltaVision® 150 <input type="checkbox"/> DeltaVision® 150 Plus <input type="checkbox"/> DeltaVision® 150 Plus with Easy Options	<b>Plan (if applicable)</b> <input type="checkbox"/> High Option <input type="checkbox"/> Low Option	<b>Coverage Type (check one)</b> <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child <input type="checkbox"/> Employee + Children <input type="checkbox"/> Employee + Family <input type="checkbox"/> Employee + Domestic Partner (if offered under your vision plan)
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**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)
<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						
<input type="checkbox"/> Add <input type="checkbox"/> 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 F: AUTHORIZATION AND CERTIFICATION**

I authorize vision care providers, vision care providers' office personnel, and other health care professionals and entities to disclose to Stryden, Inc., 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 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 vision information may be used and disclosed, and how you can get access to this information, please visit [DeltaDentalVA.com/privacypractices.aspx](http://DeltaDentalVA.com/privacypractices.aspx). To request a printed copy of the privacy notice, contact us at Stryden, Inc., attention: Privacy Unit, 4818 Starkey Road, Roanoke, VA 24018 or by calling 800-237-6060.

**Stryden, Inc. Privacy Practices**

Protecting the privacy and confidentiality of information about our customers is very important to 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:

Stryden, Inc.  
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 or required by law.
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.