Small group application guide

For more information, contact your Delta Dental of Virginia representative.

Section 1

A Effective date

B Contract period

C Group information

D Billing information

E ID card and group correspondence information.

Section 2

A If a Delta Dental PPO™ or Delta Dental PPO plus Premier® was sold, fill in rates here.

A If a Delta Dental PPO or Delta Dental PPO plus Premier was sold with a Delta Dental PPO™ — EPO Plan Design (EPO Plan) or another low option, fill in rates here. B Then, complete EPO Plan or other low option rates here; or, if the EPO Plan is chosen as a standalone, fill in rates here. The EPO Plan can be a standalone or low option product. C Employer Contribution Percentage. D If a standalone DeltaVision® plan is chosen, fill in rates here. E If you are also selecting a high/low benefit structure, complete the low option in D and the high option in E. Then complete F for employer vision contribution percentage.

DELTA DENTAL | DeltaVision®

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.**

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

C 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 ( )

D

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	

E **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)

A SECTION 2: Monthly Rates & Employer Contribution

**Dental plans underwritten by Delta Dental of Virginia*

B *Delta Dental PPO™ or Delta Dental PPO plus Premier™ Rates:*
*Employee $*______ *Emp/Spouse $*______ *Emp/Child(ren) $*______ *Emp/Family $*______

C *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.*

D *DeltaVision 130, DeltaVision 150, DeltaVision 150 Plus, DeltaVision 150 Plus with EasyOptions Rates:*
*Employee $*______ *Emp/Spouse $*______ *Emp/Child(ren) $*______ *Emp/Family $*______

E *DeltaVision high option rates:*
*Employee $*______ *Emp/Spouse $*______ *Emp/Child(ren) $*______ *Emp/Family $*______

F **Employer Vision Contribution:** To Employee Rate ______% To Dependent Rate______%

Section 3

(A) Eligibility information

Section 4

(A) If an aXcess plan is sold, select the appropriate (B) Benefit Option.

Section 5

(A) If an employer-paid PPO plus Premier™ or PPO plan was sold, check the appropriate Benefit Option, and (B) complete the remaining plan options according to the benefits sold.

(A) **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)

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

aXcess™ – Available as a single option plan only

(B) 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

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

Benefit Options (A)	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

(B) **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

(A) If a voluntary, Delta Dental PPO plus Premier™ or Delta Dental PPO™ plan was sold, check the appropriate Benefit Option and (B) complete the remaining plan options according to the benefits sold.

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

Benefit Options (A)	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

(B) **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 Dual	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 ☐ 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 ☐ 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

(A) If a Delta Dental PPO™ — EPO Plan Design is sold, select the appropriate (B) Benefit Option.

(A) **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.**

(B) 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.

Section 8

A If a DeltaVision® plan is sold, select the appropriate B Benefit Option. If a high/low benefit design is chosen, the DeltaVision 130 and 150 are the low options and the DeltaVision 150 Plus and 150 Plus with EasyOptions are the high plan options. Please also C select funding type.

Section 9

A If a DeltaVision benefit enhancement is chosen, please make the appropriate selection(s) B here.

Section 10

A Website authorization is required in order to manage your plan(s) online.

A VISION COVERAGE (Underwritten by Stryden, Inc.)

SECTION 8: Employer Paid & Voluntary Plans (2 – 300 employees)

B **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
C 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

A SECTION 9: Benefit Options

KidsCare for dependents under age 26 - ☐ (check here to **add** KidsCare to plan(s) already selected above)

B **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.

A 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

Section 12

Ⓑ Agent information

PLEASE NOTE

Ⓒ *Include these items when you return this application to your Delta Dental Sales Representative.*

Ⓐ 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.