DELTA DENTAL®
Delta Dental Plan of Virginia

4818 Starkey Road, SW
Roanoke, Virginia 24014
Fax: (540) 776-8109

ENROLLMENT/CHANGE FORM

☐ **New Enrollment** ☐ **Status Change*** ☐ **Cobra** ☐ **Contract Termination**

Effective Date
Month Day Year

Group No: _____

Group Name: _____

Social Security No.
- -

SUBSCRIBER INFORMATION (Please print legibly):

LAST NAME:_____ FIRST:_____ MI____

STREET ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE NUMBER:(____)_____

Date of Birth ____/____/____ MM DD YY

Date of Hire ____/____/____ MM DD YY

Marital Status
☐ Single
☐ Married

Sex
☐ Male
☐ Female

DDPV USE ONLY:
( ) Add ( ) Reinstate
( ) Change ( ) Correct
( ) Transfer ( ) Delete
Current _____
Change _____
Date Rec'd _____
Date Proc _____
Billing Rep _____

PLAN & TYPE OF COVERAGE SELECTED

Product (check one)
☐ DeltaPreferred ☐ DeltaCare
☐ DeltaPremier ☐ DeltaVoluntary
☐ Delta Plan 70/80/100

Type (check one):
☐ Employee
☐ Employee/Spouse
☐ Employee/Child
☐ Employee/Children
☐ Employee/Family
☐ Other

*Please check the box(es) next to the reason(s) for your change:

☐ Add Dependent(s) **listed below**
☐ Remove Dependent(s) **listed below**
☐ Name Change - Previous Name_____
☐ Change Coverage
☐ Address Change Only

Reason(s) for Change:
☐ Marriage
☐ Divorce
☐ Birth or adoption of child
☐ Other _____
☐ Loss of spouse's coverage
☐ No longer dependent child
☐ Death of dependent

LIST ALL MEMBERS TO BE ENROLLED OR AFFECTED BY A CHANGE

Last (if different)	**First**	**MI**	**Sex** M/F	**Birthdate** Month/Day/Year
1. SPOUSE				
2.				
3.				
4.				
5.				
6.				

PLEASE INDICATE DENTAL OFFICE CHOICE ONLY IF DELTACARE PRODUCT IS SELECTED

Provider Name_____ Provider Number_____ Provider Loc. #_____

OTHER GROUP COVERAGE (COORDINATION OF BENEFITS)

Will you, your spouse, or any dependent children be covered under any other group dental plan while this policy is in effect? ☐ Yes ☐ No
If yes, complete the following: 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:_____

AUTHORIZATION

I authorize dentists, dental office personnel, and other health care professionals and entities to disclose to Delta Dental Plan of Virginia, 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 the purpose of collecting information in connection with enrollment, coverage reinstatement, or requests to change benefits. 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.

CERTIFICATION

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 "Reason for Change". I certify that the information supplied by me on this form is accurate to the best of my knowledge.

☐ I have been offered the opportunity to enroll in the dental program through Delta; however, I waive coverage at this time. I further understand that I will not be eligible to enroll until the next open enrollment period.

Signature:_____ Date:_____

Delta Dental Plan of Virginia Privacy Practices

Protecting the privacy and confidentiality of information about our customers is very important to Delta Dental Plan of Virginia. 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 provided by Virginia Code Section 38.2-613.
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 provided by Virginia Code Section 38.2-613, you may send a signed letter to that effect to us at the following address:

Delta Dental Plan of Virginia
Benefit Services
Attn:Privacy Coordinator
4818 Starkey Road, S.W.
Roanoke, Virginia 24014

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.