DELTA DENTAL

Group Enrollment Application

(New Enrollment/Changes to Enrollment)

Delta Dental of Virginia
4818 Starkey Road, Roanoke, VA 24018
540-989-8000 · 800-237-6060
Fax: 540-776-8109

IMPORTANT: Incomplete information will delay enrollment. Please print using a ballpoint pen, press firmly and print clearly.

Group Name:	**Effective Date**:
Group No:	**Sublocation/Division No:**

Section A: ENROLLMENT/CHANGE

☐ New Hire ☐ ADD dependent/spouse ☐ Coverage Change ☐ Reinstatement

☐ Open Enrollment ☐ TERMINATE dependent/spouse ☐ COBRA (Effective Date ___/___/___) ☐ Cancel Coverage

☐ Change/Update Information (Name ☐ - Previous Name _____, Address ☐, Telephone ☐, Other ☐) ☐ Retiree

☐ Decline Coverage - I understand that I have been offered and have elected to decline coverage under my employer sponsored dental plan with Delta Dental at this time. I will not be eligible to enroll until the next open enrollment period or in the event of a qualifying event during the coverage period.
(Sign, date and complete first line of Section B.) **Signature** _____ Date _____

Section B: EMPLOYEE INFORMATION

Last Name	First Name	MI	Social Security Number - -
			Group Assigned ID Number (if applicable)

Mailing Address (#, Street, Apt)	City	State	ZIP

Home Telephone: ( )	Date of Birth: / /	Date of Hire: / /	Marital Status: ☐ Single ☐ Married	Gender: ☐ Male ☐ Female

If married, will your spouse or dependents have coverage under another group dental plan on the date this plan becomes effective? ☐ No ☐ Yes

Section C: COVERAGE

Product/Plan (Check Product and Plan (if applicable))

☐ **Delta Dental PPO plus Premier**
☐ **Delta Dental Premier**
☐ **DeltaCare***

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

* If applicable, use Spouse when domestic partner coverage offered under your dental plan.

*** DELTACARE ONLY – Please indicate DeltaCare dentist selection:**

Dentist Name	Dentist or Facility ID# (Refer to Directory or Delta Dental website) ( )

Section D: LIST ALL MEMBERS TO BE ENROLLED (*For Change: Indicate Reason for Change Below)

Last Name (if different)	First Name, MI	Relationship	Sex (M/F)	Date of Birth (MM/DD/YY)	Other Dental Insurance Coverage: List Carrier (including Medicare), Policy #, Effective Date
		Employee			
		Spouse			

*** Reason(s) for Change:** ☐ Marriage ☐ Loss of other group coverage ☐ Divorce ☐ No longer dependent child ☐ Birth or adoption of child ☐ Death of spouse/dependent ☐ Other_____

Date of Qualifying Event: _____

Section E: AUTHORIZATION AND CERTIFICATION

I authorize dentists, dental office personnel, and other health care professionals and entities to disclose to Delta Dental 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 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 Change" in Section D. 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. Under DeltaCare, in the event you fail to select a dentist in the DeltaCare network, you hereby authorize Delta Dental to select a dentist on your behalf so that your enrollment may be complete. You also authorize Delta Dental to change your selection, if you select a dentist not in Delta Dental of Virginia DeltaCare network or your dentist no longer participates with the Delta Dental of Virginia DeltaCare network.

Signature: _____ Date:_____