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 ball point pen, press firmly and print clearly.

Group Name: Staunton City/Staunton Schools (SAW Consortium)	**Effective Date:**
Group No: 600290	**Sublocation/Division No:**

Section A: ENROLLMENT/CHANGE (For qualifying event provide date and reason in section D)

☐ New Hire ☐ ADD dependent/spouse/domestic partner ☐ Coverage Change ☐ Reinstatement ☐ Cancel Coverage
☐ Open Enrollment ☐ DROP/Terminate dependent/spouse/domestic partner ☐ COBRA (Effective Date ___/___/___)
☐ 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 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/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	Marital Status	If married, will your spouse or dependents have coverage under another group dental plan on the date this plan becomes effective?
( )	/ /	☐ Male ☐ Female	☐ Single ☐ Married	☐ No ☐ Yes

Email Address ☐ I agree to receive communications regarding my group plan via the email address I have supplied on this application.

Date of Hire	Number of Hours Worked Per Week	Payroll Status
/ /		

Section C: COVERAGE

Product (check one)
Traditional Plans
☐ Delta Dental PPO℠ plus Premier ☐ DeltaCare®
☐ Delta Dental PPO℠
☐ Delta Dental Premier®

Plan (if applicable)
☐ High Option
☐ Low Option

Coverage Type (check one)
☐ Employee ☐ Employee/Spouse
☐ Employee/Child ☐ Employee/Family
☐ Employee/Children
☐ Employee/Domestic Partner (if offered under your dental plan)

Section D: LIST ALL MEMBERS TO BE ENROLLED (Check Reason for Change Below)

	Last Name (if different)	First Name, MI	SSN	Relationship	Gender (M/F)	Date of Birth (MM/DD/YYYY)	DELTACARE ONLY Dentist (First/Last Name)	DELTACARE ONLY Provider#
☐ Add ☐ Drop								
☐ Add ☐ Drop								
☐ Add ☐ Drop								
☐ Add ☐ Drop								
☐ Add ☐ Drop								

Date of Qualifying Event / /

Reason(s) for Qualifying Event ☐ Marriage ☐ Loss of other group coverage ☐ Divorce ☐ No longer dependent ☐ Birth or adoption ☐ Death of spouse/dependent ☐ Other ____________

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: ____________

Delta Dental of Virginia Privacy Practices

Protecting the privacy and confidentiality of information about our customers is very important to Delta Dental 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 of Virginia
   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 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 4 of this notice or (b) call us at 1-800-237-6060.