DELTA DENTAL | DeltaVision®

Delta Dental of Virginia
DeltaVision is underwritten by Stryden, Inc.
5415 Airport Road, Roanoke, VA 24012
800.237.6060 • DeltaDentalVA.com

Delta Dental Small Business Application

Instructions:
Step 1: Complete **sections 1 through 3** for all groups.
Step 2: Complete **4 through 9** for the plans being offered.
Step 3: Complete **10 and 11** for all groups. **Group administrator must sign and date.**
Step 4: Complete **13** (if applicable) with agent information. **Agent must sign and date.**

Requested effective date _____ Contract length: ☐ 1 year ☐ 2 years

SECTION 1: Group information (please print clearly, using black ink.)

Group name			
Physical address	City	State	ZIP
Mailing address (if different from physical address)	City	State	ZIP
Group administrator	Email	Phone	
Billing contact (primary) ☐ Same as group administrator	Email	Phone	
Billing contact (secondary)	Email	Phone	
Billing address ☐ Same as mailing address	City	State	ZIP
EIN/TIN	North American Industry Classification System (NAICS code)		

SECTION 2: Vision and dental monthly rates and required employer contribution

Dental rates:

Employee $_____ Emp/Spouse $_____ Emp/Child(ren) $_____ Emp/Family $_____

Dental rates — low option (if applicable)

Employee $_____ Emp/Spouse $_____ Emp/Child(ren) $_____ Emp/Family $_____

Employer dental contribution: To employee rate _____**%**

DeltaVision® rates:

Employee $_____ Emp/Spouse $_____ Emp/Child(ren) $_____ Emp/Family $_____

DeltaVision rates — low option (if applicable):

Employee $_____ Emp/Spouse $_____ Emp/Child(ren) $_____ Emp/Family $_____

Employer vision contribution: To employee rate _____**%**

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 20 hours per week; (2) is certified as being eligible by the group; (3) receives compensation from the group; and/or (4) is a member of the group as specified in the group contract.

Total eligible less those with other coverage	Total eligible enrolled

DENTAL COVERAGE (underwritten by Delta Dental of Virginia)

SECTION 4: Employer paid traditional plans (2-49 employees)

aXcess™ — Available as a single option plan only or as the low option of an employer paid traditional high/low plan only.

Benefit options	**Check one:** ☐ 100/80/25/25 ☐ 100/80/50/0
Lifetime deductible	$50
Annual maximum and lifetime ortho maximum	$2,000/$500
Major (Type III)	No benefit waiting period
Ortho (Type IV)	No benefit waiting period

SECTION 5: Employer paid traditional plans (5-99 employees)

Benefit options	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 — Option A ☐ 100/80 80/60 50/30 50/50 — Active — Option B ☐ 100/90 50/30 50/30 50/50 — Active — Option C

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 EPO™	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 and 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 and basic care (Type I and II)	Composite fillings on all teeth ☐ Yes ☐ No Endodontics/periodontics/oral surgery* ☐ Type II **or** ☐ Move to Type III	
Majors (Type III) *(Type I and II required) Indicate if covered and benefit waiting period.*	☐ Yes ☐ No	☐ Yes ☐ No
	☐ None ☐ 6 months ☐ 12 months	☐ None ☐ 6 months ☐ 12 months

Ortho (Type IV)** *(Type I-III required)* *Indicate if covered and benefit waiting period.*	☐ Yes ☐ No	
	☐ Adult and eligible dependent child(ren) ☐ Eligible dependent child(ren)	
	☐ None ☐ 6 months ☐ 12 months	

SECTION 6: Voluntary traditional plans (2-300 enrolled employees)

Benefit options	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 — Option A ☐ 100/80 80/60 50/30 50/50 — Active — Option B ☐ 100/90 50/30 50/30 50/50 — Active — Option C

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 EPO™ — 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 and 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 and basic care (Type I and II)	Composite fillings on all teeth ☐ Yes ☐ No Endodontics/periodontics/oral surgery* ☐ Type II **or** ☐ Move to Type III	
Majors (Type III) *(Type I and II required)* *Indicate if covered and benefit waiting period.*	☐ Yes ☐ No	☐ Yes ☐ No
	☐ None ☐ 6 months ☐ 12 months	☐ 6 months ☐ 12 months
Ortho (Type IV) ** *(Type I-III required)* *Indicate if covered and benefit waiting period.*	☐ Yes ☐ No	
	☐ Adult and eligible dependent child(ren) ☐ Eligible dependent child(ren)	
	☐ 12 months	

SECTION 7: Delta Dental EPO™ — Available as a single option plan or as the low option of a high/low plan only.

Benefit options *(check one)*	☐ Plan CP140 ☐ Plan CP360
Annual deductible *(check one)*	No deductible
Annual maximum and lifetime ortho maximum *(If applicable)* *(check one)*	☐ $2000/$2000 ☐ $3000/$2000
Major (Type III)	No benefit waiting period
Ortho (Type IV)	No benefit waiting period

* If coverage is only for Type I and II benefits, and "Move to Type III" is selected, then endodontics/periodontics/oral surgery services **are not** covered benefits.

*/**In order for Type IV (orthodontic benefits) to be offered, a minimum of ten (10) employees must be enrolled.

VISION COVERAGE (Underwritten by Stryden, Inc.)	
SECTION 8: Employer paid or voluntary plans (2-999 employees)	
DeltaVision® — 130 ☐ (check here to select plan)	
DeltaVision® — 150 ☐ (check here to select plan) **or** ☐ (check here to make this plan the high option)	
DeltaVision® — 150 Plus ☐ (check here to select plan) **or** ☐ (check here to make this plan the high option)	
DeltaVision® — 150 Plus with EasyOptions ☐ (check here to select plan) **or** ☐ (check here to make this plan the high option)	
Funding type	☐ Contributory ☐ Voluntary
SECTION 9: Additional vision benefit options	
KidsCare for dependents under age 0-26 — ☐ (check here to **add** KidsCare to plan(s) already selected above)	
LightCare™ enhancement — ☐ (check here to **add** LightCare enhancement to plan(s) already selected above)	
SECTION 10: Website authorization	
The individual(s) identified below is/are authorized to access Delta Dental of Virginia's and Stryden, Inc's (DeltaVision®) website and perform the function(s) checked. **By signing this application, the group authorizes its agent full access to the group's information.**	
First and last name of user	Email
	Phone
First and last name of user	Email
	Phone
The 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. The group shall be solely responsible for any liability arising from the use of the website account and shall indemnify, hold harmless and defend Delta Dental of Virginia and/or 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: Billing and payment (if applicable)	
The undersigned authorizes Delta Dental of Virginia to deduct monthly premium payments from the account below. The debit entry will be initiated on the first business day of the month for the current month's premium. This authorization will remain in effect until Delta Dental of Virginia receives written notification to terminate monthly payments by bank draft. Delta Dental of Virginia must receive written notification thirty (30) days prior to the monthly draft discontinuation effective date.	
Bank name	
Bank address	
Account number	
Transit/ABA number	
SECTION 12: 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	
Signee email (if not already provided):	
Signee phone (if not already provided):	

SECTION 13: 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, BE SURE TO INCLUDE:
☐ Include employee enrollment forms or spreadsheet. ☐ 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:

Nondiscrimination notice

Delta Dental of Virginia and Stryden, Inc. comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sexual orientation. Delta Dental of Virginia and Stryden, Inc. provides free aids and language services to people with disabilities, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats) and languages

If you need these services, contact the Civil Rights Coordinator. If you believe that Delta Dental of Virginia or Stryden, Inc. have failed to provide these services or have discriminated on the basis of race, color, national origin, age, disability, or sexual orientation, you may file a grievance with:

Civil Rights Coordinator
ATTN: Compliance Dept.
5415 Airport Road
Roanoke, VA 24012-1303
800.237.6060 • TTY number: 877.287.9039 • Fax: 540.491.9714
compliance@corvesta.com

You may also file a complaint with the U.S. Department of Health and Human Services at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
800.368.1019 • 800.537.7697 (TDD) • ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at: www.hhs.gov/ocr/office/file/index.html

Language Assistance Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800.237.6060 (TTY: 877.287.9039).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800.237.6060 (TTY: 877.287.9039)번으로 전화해 주십시오.

Dental plans are underwritten by Delta Dental of Virginia.

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