



**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.**

<b>Group Name:</b>	<b>Effective Date:</b>
<b>Group No:</b>	<b>Sublocation/Division No:</b>

**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: <input type="checkbox"/> Single <input type="checkbox"/> Married	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
If married, will your spouse or dependents have coverage under another group dental plan on the date this plan becomes effective? <input type="checkbox"/> No <input type="checkbox"/> 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) (      )
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**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: \_\_\_\_\_