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: Hampden-Sydney College** | **Effective Date:** |
| **Group No: 700100** | **Sublocation/Division No:** |

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

☐ New Hire ☐ ADD dependent/spouse ☐ Coverage Change ☐ Reinstatement
☐ Open Enrollment ☐ DROP dependent/spouse ☐ COBRA (Effective Date ___/___/___) ☐ Cancel Coverage
☐ Change/Update Information ☐ 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 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 that I have supplied on this application. If you do not want to receive communications about your policy via email, please check this box** ☐

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

## Section C: COVERAGE

**Product** (check one)
☐ Delta Dental PPO SM plus Premier

**Plan** (if applicable)
☐ High Option
☐ Low Option

**Coverage Type** (check one)
☐ Employee ☐ Employee/Spouse
☐ Employee/Child(ren) ☐ Employee/Family
☐ 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 | Relationship | Sex (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 | | | | | | | |

**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: _____