DELTA DENTAL®

Application for Individual Dental Coverage with Vision Option

STRYDEN, Inc. | DeltaVision® In partnership with VSP®

Please send completed application to:
Delta Dental of Virginia
P.O. Box 103
Stevens Point, WI 54481
Fax: 800-807-1970

PLEASE TYPE OR PRINT IN BLACK INK.
BE SURE APPLICATION IS COMPLETED IN FULL.
Customer Service: 888-899-3736
DeltaDentalCoversMe.com

Section 1 | Policyholder Information

Policyholder Last Name	First Name	Middle Initial	Gender: Male/Female

Home Address (Mailing)	City	State	ZIP	Phone No. (with area code)

Email Address*	Date of Birth	Marital Status: ☐ Single ☐ Married

☐ *By checking this box, you agree to receive communication electronically. You can choose to no longer receive electronic communication at any time by calling Customer Service at (888-899-3736).

Dental Plan Selection

☐ ClearPlus Plan ☐ *Basic Plan ☐ *Classic Plan ☐ *Enhanced Plan ☐ *Premium Plan ☐ *Progressive Plan

To learn more about plan designs, visit DeltaDentalCoversMe.com or call 888-899-3736.

These plan designs require that the policyholder be a covered person.

ADD VISION BENEFIT. If selected, all persons covered under dental will also be covered under vision.

☐ Yes ☐No ☐ DeltaVision® – ☐ Essential 150 ☐ Brilliance 200

Employment Status: ☐ Employed ☐ Self-employed ☐ Retired ☐ Not currently working

Reason for Application: ☐ New Enrollment ☐ Change of Dependent(s)

Section 2 | Persons to be covered

(Include YOURSELF if applying for coverage)

First Name	Last Name	Date of Birth	Relationship to Policyholder (Self, Spouse or Dependent Child)	Gender M/F	Disabled Child Y/N

Policies issued in the State of Virginia are underwritten by: Delta Dental of Virginia, NAIC #55611, 4818 Starkey Road, Roanoke, VA 24018. All policies are administered, at least in part, by Delta Dental of Wisconsin and/or its subsidiary, Wyssta Services, Inc. DeltaVision is underwritten by Stryden, Inc., an affiliate of Delta Dental of Virginia. Claims processing, claims service and provider network administration for DeltaVision are provided under contract by VSP.

PRIOR DENTAL INSURANCE COVERAGE. Were the above persons covered by a dental plan in the past 63 days? ☐ Yes ☐ No

Previous Carrier	Beginning Date	Ending Date

Section 3 | Payment Instructions

To calculate rates please visit DeltaDentalCoversMe.com or call 888-899-3736.
A debit, credit card or electronic funds transfer (EFT) may be used to pay monthly, semi-annually, or annually. If paying by check, remittance for the full annual 12-month premium is required, payable to Delta Dental.

Choose payment method: ☐ Debit/Credit Card ☐ Annual Check ☐ EFT**

**Applications received on or after the 25th of the month must use a credit card if requesting a first of the following month effective date. If EFT payment is selected, your effective date will be adjusted to the first of the next month. Following the initial premium payment, your payment type can be updated at any time by logging in to DeltaDentalCoversMe.com or by calling 888-899-3734.

Please complete the following information for payment by debit/credit card:

Card Type: ☐ Visa ☐ MasterCard ☐ Discover
Cardholder Name:_____
Cardholder Address (if different than Policyholder): _____
City:_____ State: _____ ZIP Code:_____
Card Number:_____
Expiration Date: Month _____ Year _____ Security Code (from back of card): _____
Payment Frequency: ☐ Monthly ☐ Semi-annually ☐ Annually

Please complete the following information for payment by electronic funds transfer (EFT):

Name of Financial Institution:_____
Financial Institution's City, State and ZIP Code: _____
Type of Account (Choose One): ☐ Checking ☐ Savings Name on Account:_____
Bank Routing Number:_____ Bank Account Number:_____

Please attach a voided check to this application if you will be using your checking account for automatic payments.

I authorize Delta Dental of Virginia to initiate debit entries from my above bank account or Debit/Credit card for my dental premiums

Signature: _____ **Date:** _____

Your initial payment is due when the application is processed. Additional payments for upcoming periods will be deducted from your account on the month prior to its due date. If the charge is declined for any reason, we will attempt to charge you again the following month. If the charge is still declined, we will immediately terminate your contract for nonpayment of premium, effective as of the last day of the grace period.

In submitting this application to Delta Dental of Virginia for dental coverage, I agree and understand that this application will become part of the Policy and I agree to be bound by the terms of the Policy issued by Delta Dental. I understand that this is a contract under which I am obligated to pay premiums for the term of the contract. I further agree that the coverage requested is subject to the approval of Delta Dental and that no representative has authority to make changes or modify this application for coverage.

I certify that all of the information contained in this application is true and correct to the best of my knowledge. I further understand that misrepresentation of submitted data may cause this application and subsequent Policy to be null and void. In the event it is discovered that I have provided false or misleading information in connection with this application for the purpose of defrauding Delta Dental of Virginia, Delta Dental may inform the appropriate state and regulatory authorities, including, but not limited to, my state's insurance commissioner.

By my submission of this application, I attest that I do not have other active, dental coverage. If at any time I obtain other dental coverage, Delta Dental reserves the right to terminate this plan with thirty (30) days' notice.

The Policy will become effective on the first day of the month following approval of this application.

Policyholder Signature **Date**

Coverage is contingent upon underwriting acceptance.

Agency Use Only	*Agency Name or Code:*		*Agent Name:*		*Agent #:*	

Commission payment may not be supported for all products. Please contact Delta Dental for more information.