DELTA DENTAL®

Small group application guide

Below is a step-by-step guide for completing the Delta Dental of Virginia Small Business Application. Please complete each section entirely. For information or for questions about completing the application, contact your Delta Dental of Virginia representative.

First, add the:

Ⓐ Effective date and Ⓑ contract length. Then complete the remaining sections of the application.

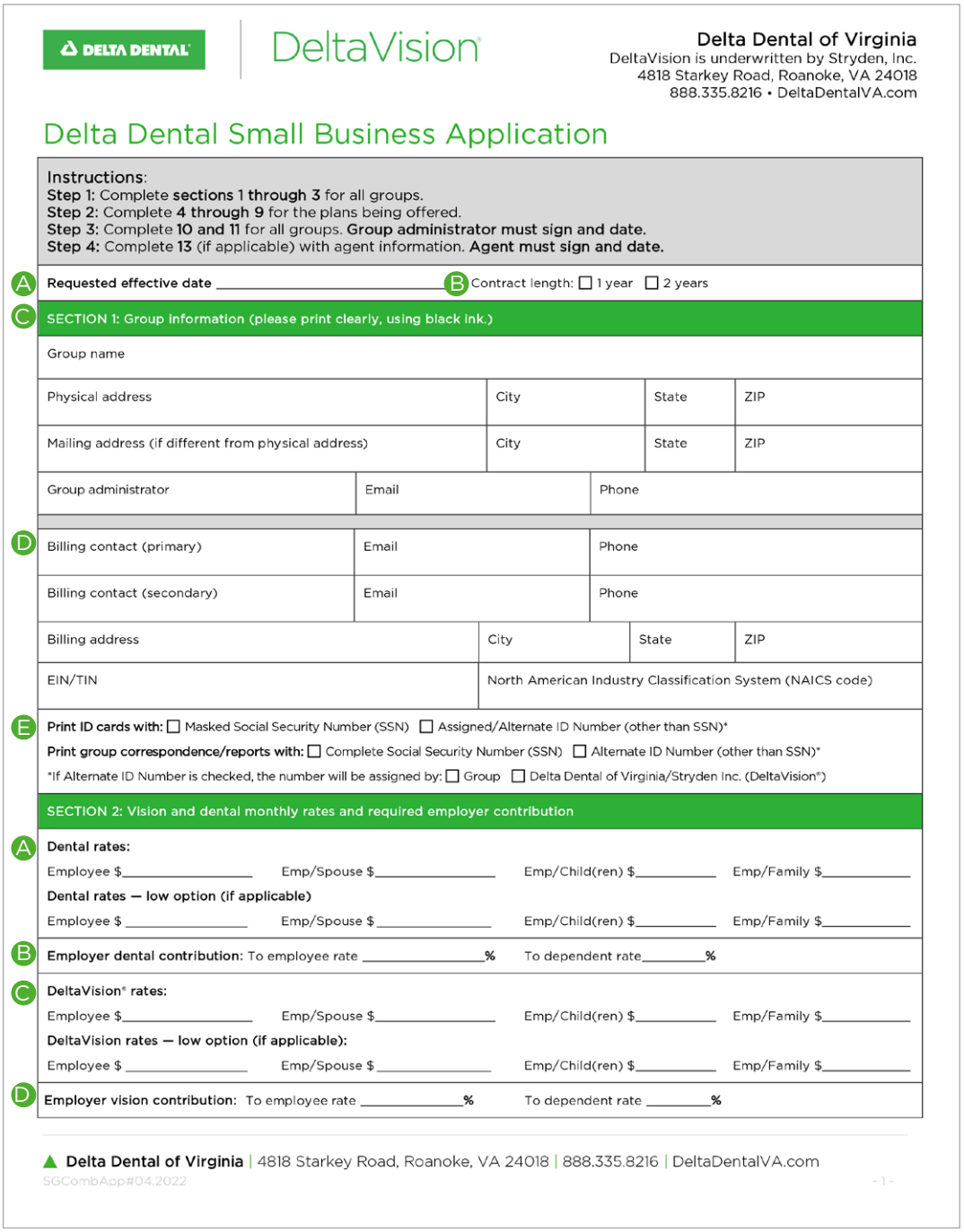
Section 1

Add Ⓒ group and Ⓓ billing information and complete Ⓔ for ID card and group correspondence.

Section 2

Ⓐ If a dental plan was sold, add rates here. Then, add Ⓑ to include the employer contribution percentage.

Ⓒ If a DeltaVision® plan is chosen, add rates here. Then add Ⓓ to include the employer vision contribution percentage.



DELTA DENTAL | DeltaVision®

Delta Dental of Virginia
DeltaVision is underwritten by Stryden, Inc.
4818 Starkey Road, Roanoke, VA 24018
888.335.8216 • 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)	Email	Phone
Billing contact (secondary)	Email	Phone

Billing address	City	State	ZIP
EIN/TIN	North American Industry Classification System (NAICS code)		

Ⓔ **Print ID cards with:** ☐ Masked Social Security Number (SSN) ☐ Assigned/Alternate ID Number (other than SSN)*
Print group correspondence/reports with: ☐ Complete Social Security Number (SSN) ☐ Alternate ID Number (other than SSN)*
*If Alternate ID Number is checked, the number will be assigned by: ☐ Group ☐ Delta Dental of Virginia/Stryden Inc. (DeltaVision®)

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 _____% To dependent 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 _____% To dependent rate _____%

▲ **Delta Dental of Virginia** | 4818 Starkey Road, Roanoke, VA 24018 | 888.335.8216 | DeltaDentalVA.com
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DELTA DENTAL®

Small group application guide (continued)

Section 3

Complete Ⓐ to add eligibility information.

Section 4

Ⓐ If an aXcess plan is sold, select the appropriate Ⓑ benefit option and jump to Section 8.

Section 5

Ⓐ If an employer-paid Delta Dental PPO Plus Premier™ or Delta Dental PPO™ plan was sold, check the appropriate benefit option, and Ⓑ complete the remaining plan options according to the benefits sold.

Ⓐ

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 number of employees	Employees ineligible for benefits (-)	Covered by other insurance (-)	Total eligible employees (=)	Total eligible employees enrolled

New hire waiting period: The length of time future employees must be employed before becoming eligible for coverage:
☐ 1st of the month following 90 days
☐ Match medical: ☐ Date of hire ☐ _____days ☐ Other _____
Following any applicable new hire waiting period, coverage becomes effective: ☐ 1st of the month ☐ Exact date

When coverage ends: At the time of termination (except for over age dependent), coverage ends:
☐ Last day of month ☐ Match medical — exact date ☐ Other _____

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	
	☐ None ☐ 6 months ☐ 12 months	

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DELTA DENTAL®

Small group application guide (continued)

Section 6

Ⓐ If a voluntary Delta Dental PPO Plus Premier™ or Delta Dental PPO™ plan was sold, check the appropriate benefit option and Ⓑ complete the remaining plan options according to the benefits sold.

Section 7

Ⓐ If a Delta Dental EPO™ plan was sold, select the appropriate Ⓑ benefit option.

Section 8

Ⓐ If a DeltaVision® plan was sold, select the appropriate Ⓑ benefit option. If a high/low benefit is chosen, the DeltaVision — 130 and DeltaVision — 150 are the low plan options and the DeltaVision — 150 Plus and DeltaVision — 150 Plus with EasyOptions are the high plan options. Then select Ⓒ funding type.

	SECTION 6: Voluntary traditional plans (5-300 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 #.	
		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	
		☐ 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

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DELTA DENTAL®

Small group application guide (continued)

Section 9

Ⓐ If a DeltaVision® benefit enhancement is chosen, make those selection(s) Ⓑ here.

Section 10

Ⓐ Website authorization is required in order to manage your plan(s) online.

Section 11

Complete Ⓐ for billing and payment information.

Section 12

Complete Ⓐ with the group administrator information. This section requires Ⓑ the group administrator's signature.

Section 13

Complete Ⓐ to include agent information. This section requires Ⓑ the agent's signature.

NOTE:

Ⓐ ***Include these items when you return this application to your Delta Dental of Virginia sales representative.***

Ⓐ **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:

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