



5415 Airport Road • Roanoke, VA 24012

Please send completed application to:

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

Application for Individual Coverage
 Dental and Vision Options

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 <input type="checkbox"/> Single <input type="checkbox"/> Married	
<input type="checkbox"/> I wish to receive communications electronically rather than by paper. I understand that I can rescind this choice by calling Customer Service at (888-899-3736).				
Dental Plan Selection: <input type="checkbox"/> ClearPlus Plan <input type="checkbox"/> Basic Plan* <input type="checkbox"/> Classic Plan* <input type="checkbox"/> Enhanced Plan* <input type="checkbox"/> Premium Plan* <input type="checkbox"/> Progressive Plan* <input type="checkbox"/> Million Dollar Smile Plan* <input type="checkbox"/> No Dental Plan selected				
Vision Plan Selection: <input type="checkbox"/> DeltaVision® Brilliance 200 Plan* <input type="checkbox"/> DeltaVision® Essential 150 Plan* <input type="checkbox"/> No DeltaVision® Plan selected 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.				
Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Self-employed <input type="checkbox"/> Retired <input type="checkbox"/> Not currently working				
Reason for Application: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Change of Dependents				

This is an excepted benefits policy. It provides coverage only for the limited benefits or services specified in the policy.

Dental policies issued in the State of Virginia are underwritten by Delta Dental of Virginia, NAIC #55611, 5415 Airport Road, Roanoke, VA 24012 and administered 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, and administered by VSP.

Ind.MultiApp#06.2025



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SECTION 2: PERSONS TO BE COVERED						
<i>(INCLUDE YOURSELF IF APPLYING FOR COVERAGE)</i>						
First Name	Last Name	Date of Birth	Relationship to Policyholder (self, spouse, or dependent child)	Gender M/F	Disabled Child Y/N	Select dental and/or vision coverage
						<input type="checkbox"/> Dental <input type="checkbox"/> Vision
						<input type="checkbox"/> Dental <input type="checkbox"/> Vision
						<input type="checkbox"/> Dental <input type="checkbox"/> Vision
						<input type="checkbox"/> Dental <input type="checkbox"/> Vision
						<input type="checkbox"/> Dental <input type="checkbox"/> Vision

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

For dental coverage, is this policy intended to replace any other dental insurance currently in force?
 Yes No

For vision coverage, is this policy intended to replace any other vision insurance currently in force?
 Yes No

SECTION 3: PAYMENT INSTRUCTIONS
<p>To calculate rates please visit DeltaDentalCoversMe.com or call 888-899-3736.</p> <p>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.</p> <p>Choose payment method: <input type="checkbox"/> Debit/Credit Card <input type="checkbox"/> Annual Check <input type="checkbox"/> EFT**</p> <p>**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.</p> <p>Please complete the following information for payment by debit/credit card:</p> <p>Card Type: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover</p> <p>Cardholder Name: _____</p> <p>Cardholder Address (if different than Policyholder): _____</p> <p>City: _____ State: _____ ZIP Code: _____</p> <p>Card Number: _____</p> <p>Expiration Date: Month _____ Year _____ Security Code (from back of card): _____</p> <p>Payment Frequency: <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-annually <input type="checkbox"/> Annually</p>



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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 terminate your contract for nonpayment of premium after the expiration of the grace period.

In submitting this application to Delta Dental of Virginia for 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 and/or Stryden. 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/or Stryden 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 and/or Stryden, Delta Dental and/or Stryden may inform the appropriate state and regulatory authorities.

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

If the Policy was purchased with the assistance of an agent, the undersigned applicant and agent certify that the applicant has read, or had read to him, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

POLICYHOLDER SIGNATURE

DATE

Agency Use Only	Agency Name or Code:	Agent Name:	Agent Signature:	Agent #:	
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Commission payment may not be supported for all products. Please contact Delta Dental for more information.