DELTA DENTAL®

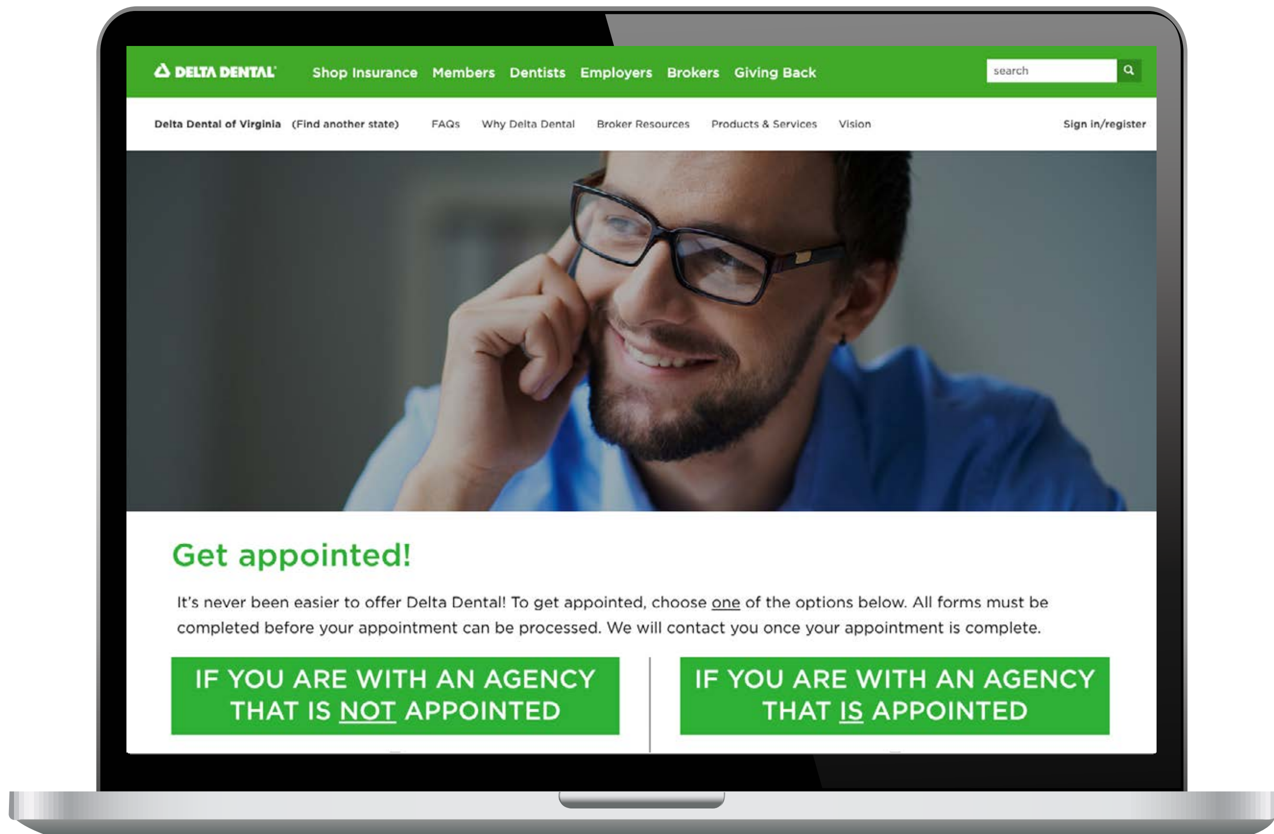
Welcome to Delta Dental!

Thank you for offering Delta Dental and DeltaVision! Once a product is sold, follow these steps to complete the onboarding process for your new client:

1. If you are appointed with Delta Dental of Virginia skip to step 2. If not, visit DeltaDentalVA.com/brokers/get-appointed and follow the instructions to become appointed.
2. Complete the following documents entirely and submit to smallbizsupport@deltadentalva.com. Any incomplete documents may delay the implementation of the group.

Documents that must be submitted:

- Small Business Group Application (included with this packet)
- Enrollment spreadsheet or employee enrollment applications
- Attach the quote
- Prior carrier statement (only if waiving the 12-month waiting period for orthodontics).



DELTA DENTAL®

Service you can count on

Once all documents are submitted, the Group Administrator listed on the Small Business Group Application and the submitting broker (if applicable) will receive a welcome email within 15 business days that contains the following:

- Welcome letter
- Dental and/or vision contract
- Dental and/or vision EOC
- How to service your group
- Virginia Guaranty Association notice

PLAN NAME APPEARS HERE

Group Name: Delta Dental of Virginia
Group Number: 0000000000-000000-0000
Subscriber: Jane Doe
ID Number: XXXXX000
Effective Date: XX/XX/XXXX

SAMPLE

Delta Dental of Virginia, 4818 Starkey Road, Roanoke, VA 24018
Electronic Claims Payor: 54084
800-237-6060 • DeltaDentalVA.com
Delta Dental is a Registered Mark of Delta Dental Plans Association.

Members will receive ID cards at home within 15 business days after completed submission.

Have a question? See the contact sheet on the next page to find your area sales representative.

DELTA DENTAL®

Contacts

Virginia Corporate Headquarters — Roanoke	800.572.3044

SALES TEAM

NAME	SERVICE AREA	CONTACT INFO
Jason Reynolds, *Senior Sales Representative*	Northern	**804.297.3267** jcreynolds@deltadentalva.com
Diane Watson, *Sales Representative*	Eastern	**804.297.3264** dhwatson@deltadentalva.com
John Wilson, *Sales Executive*	Western	**540.776.8114** jwilson@deltadentalva.com
Will Muller, *Sales Representative*	Central	**540.824.2639** will.muller@deltadentalva.com

ACCOUNT MANAGEMENT

NAME	SERVICE AREA	CONTACT INFO
Anne Muranowski, *Small Business Client Specialist*	Central and Western	**540.795.4512** anne.muranowski@deltadentalva.com
Christy Schaeffer, *Small Business Client Specialist*	Northern and Eastern	**540.795.4527** christy.schaeffer@deltadentalva.com

OPERATIONS

CUSTOMER SERVICE	800.237.6060; Fax (540) 491.9717
• Customer inquiries and benefit questions	customerservice.helpdesk@deltadentalva.com
BROKER SERVICES	
• Appointments • Agent and agency appointment terminations • Agency and agent addresses and other information • Broker of Record changes • Commission payment inquiries	brokerhelp@deltadentalva.com
MARKETING ADMINISTRATION (GROUP BUSINESS)	**888.335.8216; Fax (540) 774.7574**
• Group set-up and maintenance • Requests for information and printed materials for existing groups • Document creation and retention	mktgadmin@deltadentalva.com
INDIVIDUAL BUSINESS	**540.562.8020**
Sam Austin, product manager, individual business	sam.austin@deltadentalva.com
BILLING	**800.237.6060; Fax (540) 776.8109**
• Billing, enrollment and eligibility	billing@deltadentalva.com
ELECTRONIC ELIGIBILITY	**800.237.6060; Fax (540) 776.8109**
• Electronic eligibility set-up and maintenance	eecoordinatornotifications@deltadentalva.com

Delta Dental of Virginia
DeltaVision is underwritten by Stryden, Inc.
5415 Airport Road, Roanoke, VA 24012
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 8** for the plans being offered.
Step 3: Complete **9 and 10** for all groups. **Group administrator must sign and date.**
Step 4: Complete **12** (if applicable) with agent information. **Agent must sign and date.**

Submit completed forms and all required documents to smallbizsupport@deltadentalva.com.

Requested effective date ______________________________ Contract length: ☒ 1 year

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) ☐ Same as Group Administrator	Email	Phone
Billing contact (secondary)	Email	Phone

Billing address ☐ Same as Mailing 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 __________**%**

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 eligible less those with other coverage	Total eligible enrolled

DENTAL COVERAGE (underwritten by Delta Dental of Virginia)

SECTION 4: Employer paid traditional plans (available to groups with 2-49 employees)

aXcess™ 25 — Available as a single option plan only or as the low option of an employer paid traditional high/low plan only.

Benefit options	**Check here:** ☐ 100/80/25/25
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 (available to groups with 2-4 employees)

aXcess™ 50 — Available as a single option plan only or as the low option of an employer paid traditional high/low plan only.

Benefit options	**Check here:** ☐ 100/80/50/0
Lifetime deductible	$50
Annual maximum and lifetime ortho maximum	$2,000/N/A
Major (Type III)	No benefit waiting period
Ortho (Type IV)	No benefit waiting period

SECTION 6: Employer paid traditional plans (available to groups with 5-200 employees)

Benefit options	Delta Dental PPO Plus Premier™ ☐ 100/80/50/50 — Passive	
Plan options		
Check one	☐ Single option 1) Complete the single option column. ☐ High/low option 1) Complete both the high and low option columns	
	Single option or high option	**Low option***
Annual deductible *(check one)*	☐ $50	☐ aXcess 25 ☐ aXcess 50
Annual maximum and lifetime ortho maximum *(if applicable) (check one)*	☐ $1000/$1000 ☐ $1500/$1500 ☐ $2500/$2500	☐ aXcess 25 ☐ aXcess 50
Diagnostic/preventive and basic care (Type I and II)	Composite fillings on all teeth ☒ Yes Endodontics/periodontics/oral surgery ☒ Type II	
Ortho (Type IV)** *(Type I-III required) Indicate if covered and benefit waiting period.*	☐ Yes ☐ No ☐ Adult and eligible dependent child(ren)	

SECTION 7: Voluntary traditional plans (available to groups with 5-300 enrolled employees)		
Benefit options	Delta Dental PPO Plus Premier™: ☐ 100/80/50/50 — Passive	
Plan options		
Check one	☐ Single option — 1) Complete the single option column. ☐ High/low option — 1) Complete both the high and low option columns.	
	Single option or high option	**Low option***
Annual deductible *(check one)*	☐ $50	☐ aXcess 25 ☐ aXcess 50
Annual maximum and lifetime ortho maximum *(if applicable) (check one)*	☐ $1000/$1000 ☐ $1500/$1500 ☐ $2500/$2500	☐ aXcess 25 ☐ aXcess 50
Diagnostic/preventive and basic care (Type I and II)	Composite fillings on all teeth ☒ Yes Endodontics/periodontics/oral surgery ☒ Type II	
Major (Type III) *(Type I-II required)*	No benefit waiting period	
Ortho (Type IV)** *(Type I-III required)* *Indicate if covered and benefit waiting period.*	☐ Adult and eligible dependent child(ren)	
	☐ Yes ☐ No	
	☐ 0 months ☐ 12 months	

*Must choose either aXcess™ 25 or aXcess™ 50.
**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 (available to groups with 2-200 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

SECTION 9: 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 10: Billing and payment

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 (Name of financial institution)

Bank address (Address of financial institution)

Account number (Financial institution account number)

Transit/ABA number (Financial institution routing number)

SECTION 11: 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 12: 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.

☐ Applicable quote.

INTERNAL USE ONLY:

Nondiscrimination notice

Delta Dental of Virginia and Stryden, Inc. comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sexual orientation. Delta Dental of Virginia and Stryden, Inc. provides free aids and language services to people with disabilities, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats) and languages

If you need these services, contact the Civil Rights Coordinator. If you believe that Delta Dental of Virginia or Stryden, Inc. have failed to provide these services or have discriminated on the basis of race, color, national origin, age, disability, or sexual orientation, you may file a grievance with:

Civil Rights Coordinator
ATTN: Compliance Dept.
5415 Airport Road
Roanoke, VA 24012
800.237.6060 • TTY number: 877.287.9039 • Fax: 540.491.9714
compliance@corvesta.com

You may also file a complaint with the U.S. Department of Health and Human Services at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
800.368.1019 • 800.537.7697 (TDD) • ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at: www.hhs.gov/ocr/office/file/index.html

Language Assistance Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800.237.6060 (TTY: 877.287.9039).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800.237.6060 (TTY: 877.287.9039)번으로 전화해 주십시오.

Dental plans are underwritten by Delta Dental of Virginia.

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. VSP, LightCare and WellVision Exam are registered trademarks, VSP Diabetic Eyecare Plus Program is a service mark of Vision Service Plan. All other brands or marks are the property of their respective owners.