Covered under two dental plans?

"Dual coverage" is when dental treatment is covered by more than one insurance company. It does not mean your coverage is doubled; instead, your out-of-pocket expenses may be reduced by what's called a coordination of benefits. It works exactly like it sounds — Delta Dental of Virginia will coordinate your benefits with the other insurance company to determine what each dental plan you are covered by will pay.

Which insurance plan pays first?

Your Evidence of Coverage (EOC) or Summary Plan Description (SPD) document provides details on which insurance plan would be considered primary (pays first, or processes the claim first) and which would be considered secondary (pays second, or processes the claim second).

What do we need from you?

Complete the coordination of benefits form and submit it by:

Email: CustomerService.Helpdesk@deltadentalva.com

Mail: Delta Dental of Virginia
P.O. Box 12483
Roanoke, VA 24026

Learn about using your dental benefits, access online member tools, download oral health information and more at DeltaDentalVA.com.

DELTA DENTAL®

Coordination of Benefits Form

Complete this form then mail it to the address at the bottom of this page or email it to CustomerService.HelpDesk@deltadentalva.com.

Section 1 — Delta Dental of Virginia subscriber information

Subscriber name: _____ **Member number:** _____
(Found on your Member ID card) (Found on your Member ID card)

Are you, your spouse or any of your dependents covered by another dental plan?

☐ **Yes** — For you ☐ **Yes** — For spouse ☐ **Yes** — For dependents
☐ **No** — If no, sign and return this form to Delta Dental of Virginia according to the instructions noted above.

If you selected Yes from any of the above, complete this form in its entirety, sign it and return per the instructions above.

Section 2 — Other dental insurance information

If more than one additional plan exists, copy this document and provide information for each additional dental insurance plan covering you and/or your family members.

Policyholder information

Policyholder name: _____ Policyholder member ID: _____

Policyholder date of birth: _____ Employer: _____

Other dental insurance carrier information

Dental insurance carrier name: _____ Group number: _____

Address: _____ City: _____ State: ____ ZIP: _____

Hire date (required): _____ Term date (if applicable): _____

Type of plan:

☐ Dental — Employer based ☐ Dental — Self enrolled ☐ State funded — Medicaid ☐ Medicare Advantage

☐ Dental embedded in medical policy ☐ Other (explain): _____

Who is covered under this dental plan? (check all that apply) ☐ Self ☐ Spouse ☐ Dependent(s)

Name (First and last)	Relationship type (see options below)	Start date of coverage*

Select the option that best describes the relationship between the listed dependents and the policyholder:

1. Two biological or adoptive parents
2. Two legal guardians
3. One biological parent and one legal guardian
4. One biological parent or legal guardian and one step-parent
5. Two step-parents
6. Other, (explain): _____

*Date the policyholder was originally eligible for and covered by a dental plan.

Continued on next page

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Coordination of Benefits Form (continued)

Section 2 — Other dental insurance information (continued)

Do both policyholders live at the same address? ☐ Yes ☐ No

Are the policyholders legally married to each other? ☐ Yes ☐ No

If this coverage is provided by a Department of Defense health benefit program, which statement listed below is most applicable? ☐ Full-time active duty ☐ Reserves ☐ Military retiree ☐ Other: _____

Section 3 — Special situations

(Complete this section ONLY when parents are divorced, legally separated, not living together, or there is a court order.)

Is there a court order that determines responsibility for health/dental care coverage or custody?

☐ Yes – If yes, please attach a copy of the sections that apply to health/dental care coverage or custody arrangements

☐ No

Dependents name(s):

_____

_____

_____

_____

_____

_____

_____

Does the court order state who is to maintain insurance coverage for the dependent(s)? ☐ Yes ☐ No ☐ N/A

If yes, who is the responsible party? _____

Does the court order state who has what percentage of custody? ☐ Yes ☐ No ☐ N/A

If yes, who has the highest percentage and what is that percentage? _____

If there is no court order, is the subscriber's home the primary residence? ☐ Yes ☐ No ☐ N/A

Any additional information you would like to provide:

_____

_____

_____

_____

Section 4 — Signature

I certify that I have read and understand this form and that the information contained is true and completed to the best of my knowledge. I understand I am the enrollee identified or am authorized to act on behalf of the enrollee as a guardian or personal representative. I understand that I may have a copy of this form after I sign it.

Subscriber signature (required): _____

Print name: _____ Date: _____