Enrollment Application

(New Enrollment/Changes to Enrollment)

Delta Dental of Virginia
4818 Starkey Road, Roanoke, VA 24018
(540) 989-8000 • (800) 237-6060
Fax: (540) 776-8109

IMPORTANT: Incomplete information will delay enrollment. Please print using a ball point pen, press firmly and print clearly.

Group Name: New River Valley Consortium	**Effective Date**:
Group No: 700027	**Sublocation/Division No:** Pulaski County Public Schools

Section A: ENROLLMENT/CHANGE

☐ New Hire ☐ ADD dependent/spouse ☐ Coverage Change ☐ Reinstatement ☐ Retiree
☐ Open Enrollment ☐ TERMINATE dependent/spouse ☐ COBRA (Effective Date ___/___/___) ☐ Cancel Coverage
☐ Change/Update Information (Name ☐ - Previous Name ______________________________, Address ☐, Telephone ☐, Other ☐)
☐ Decline Coverage - I understand that I have been offered and have elected to decline coverage under my employer sponsored dental plan with Delta Dental at this time. I will not be eligible to enroll until the next open enrollment period or in the event of a qualifying event during the coverage period. (Sign, date and complete first line of Section B.) **Signature** ______________________________ Date ________________

Section B: EMPLOYEE INFORMATION

Last Name	First Name	MI	Social Security Number - -
Mailing Address (#, Street, Apt)		City	State / ZIP
Home Telephone: ( ) -	Date of Birth: / /	Date of Hire: / /	Marital Status: ☐ Single ☐ Married / Gender: ☐ Male ☐ Female

Section C: COVERAGE

Product/Plan ☐ **Delta Dental Premier – High Option**

Coverage Type (check one): ☐ Employee ☐ Employee/Child(ren) ☐ Employee/Spouse ☐ Employee/Family

Section D: LIST OTHER MEMBERS TO BE ENROLLED (*For Change: Indicate Reason for Change Below)

Last Name (if different)	**First Name, MI**	**Relationship**	**Sex (M/F)**	**Date of Birth (MM/DD/YY)**	**Other Dental Insurance Coverage:** List Carrier (including Medicare), Policy #, Effective Date
		SPOUSE			

*** Reason(s) for Change:** ☐ Marriage ☐ Loss of other group coverage ☐ Divorce ☐ No longer dependent child ☐ Birth or adoption of child
☐ Death of spouse/dependent ☐ Other ______________________________

Date of Qualifying Event: ______________________________

Section E: AUTHORIZATION AND CERTIFICATION

I authorize dentists, dental office personnel, and other health care professionals and entities to disclose to Delta Dental of Virginia, its agents and employees (including, without limitation, its claims and customer service personnel) all information necessary to determine (1) eligibility for coverage and (2) covered benefits. This authorization is made for each individual to be enrolled or affected by this change. The authorization is valid for 30 months from the date this form is signed for underwriting purposes. The authorization is valid for the term of coverage for the purpose of collecting information in connection with claims for benefits. The applicant or the applicant's authorized representative is entitled to receive a copy of the authorization form.

I understand that my selection of coverage may be changed only during the open enrollment period of each year unless I experience a qualifying event listed under "Reasons for Change" in Section D. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement may have violated state law. I certify that the information supplied by me on this form is accurate to the best of my knowledge.

Signature: ______________________________ Date: ________________

White: Delta Dental
Canary: Employer – Submit for Employee Termination