

Seattle Location

Washington Dental Service
P.O. Box 75983
Seattle WA 98175-0983
(206) 528-2406 or (800) 572-7835 x 2406

Spokane Location

Washington Dental Service
611 North Perry Street, Suite 200
Spokane, WA 99202-5011
(509) 532-1080 or (800) 564-8832

Group Information

New Group # (Internal Use Only)			
Legal Name of Group			
Phone Number	Fax Number		
Address	City	State	Zip
Name and Location of Parent Company (if subsidiary)			
Company Representative (name)	Title		
Company Representative E-mail Address			
Billing/Eligibility Contact Name (if different from above)	Phone Number		
Fax Number	E-mail Address		
Third Party Administrator (TPA) (if applicable)			
TPA Billing Administrator			
TPA Billing Address (if different from company representative)			

Employee Eligibility

New employee waiting period first of the month following: _____ days _____ months _____ date of hire		
Additional explanation for waiting period: _____		
Total Number of Employees: _____	Total Number of Eligible Employees: _____	Minimum Enrollment: _____
Employer Contribution: Employee _____% Dependents _____% Tied to Medical <input type="checkbox"/>		
Requested Effective Date: _____	Term of Contract: _____ to _____	

Rates	Other Rate Tiers (if applicable)
Employee Only \$	Employee + 1 \$
Employee + Spouse \$	Employee + 2 \$
Employee + Child(ren) \$	Composite \$
Employee + Spouse + two (2) or more Children \$	ASC Fee \$

Plan Description

Benefit Period: <input type="checkbox"/> Calendar <input type="checkbox"/> Contract
Program (annual) Maximum: \$ _____
Annual Deductible: Per person \$ _____ Family maximum \$ _____
Deductible Waived On: <input type="checkbox"/> Diagnostic & Preventive <input type="checkbox"/> Class II <input type="checkbox"/> Class III <input type="checkbox"/> Orthodontics <input type="checkbox"/> Other _____
Benefit Coverages: Class I _____% Class II _____% Class III _____%
Orthodontic Lifetime Maximum: \$ _____ Children Only – Yes <input type="checkbox"/> No <input type="checkbox"/> Adult & Children – Yes <input type="checkbox"/> No <input type="checkbox"/>
Temporomandibular (TMJ) Coverage: Surgical – (paid at 50% to \$1,000 annual with \$5,000 lifetime maximum) Yes <input type="checkbox"/> No <input type="checkbox"/>
Coordination of Benefits: <input type="checkbox"/> Standard (birthday rule) <input type="checkbox"/> No Dual Coverage
Domestic Partner Coverage: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, check appropriate section: <input type="checkbox"/> Any Gender <input type="checkbox"/> Same Gender
Dependent Children Covered to Age: _____ Student to Age: _____ (per RCW 48.44.215 the minimum is through age 24)
Other Specific Benefits: _____

Insurance Producer Information

Insurance Producer Name	Phone Number		
Insurance Producer Company Name	Fax Number		
Insurance Producer Address	City	State	Zip
E-mail Address			

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

The undersigned certifies that he/she represents the group or company stating its intent to commence coverage and acknowledges the appointment of the above insurance producer for her/his company.

Company Representative/Title (Please Print)

Signature

Date