

Washington Dental Service is a member of the
Delta Dental Plans Association

Seattle Location:
Washington Dental Service
P.O. Box 75983
Seattle, WA 98175-0983

(206) 528-2392 or (800) 572-7835 ext. 2392
(206) 528-2386 or (800) 572-7835 ext. 2386

Spokane Location:
Washington Dental Service
Iron Bridge Building
611 N. Perry St., Suite 200
Spokane, WA 99202-5011

(509) 535-1080 or (800) 564-8832

Group Information

New Group # _____

Group Name: _____ **Phone No.** () _____

Street Address: _____ **City, State, Zip:** _____

Billing Address: _____ **City, State, Zip:** _____
(if different from street)

Co. Representative _____
Name Title

Co Rep E-Mail Address: _____

Billing/Contact _____
Name Title

Billing E-Mail Address: _____

Type/Nature of Business: _____

Employee Eligibility

Effective Date _____

Contract Period ____/____/____ - ____/____/____

Benefit Period ____/____/____ - 12 / 31 / ____ **January through December thereafter**

Employee and Dependent Participation:

_____% subscriber and _____% dependent participation
(For groups 10 and over)
Subscriber participation must be 75% or greater.
Dependent participation must be 50% or greater

****Please NOTE:** SimpleChoice requires two applications; this one and the attached *Online Enrollment Master Application*.
All eligible employees **must** be enrolled on line through the Online Enrollment process at our Web site.

Participation tied to medical (*This is the only option for groups 5-9*)

Employer Contribution:

Employer contribution must be a minimum of 50% employer paid for group sizes of 5-99 employees

Number of Full-time Employees: _____ Minimum enrollment (check one) 5-9 10-50 51-99 100+

New Employee Waiting Period: first of the month following _____ days _____ months date of hire
(A minimum of 80 hours per month constitutes full-time employment.)

Rates:	Rate Directly from Table	Ortho Rates from Rider	Rates Sub-Total	No. of EEs @ this Rate	Premium
EE	_____ +	_____ =	_____ X	_____ =	_____
Ee+Spouse	_____ +	_____ =	_____ X	_____ =	_____
Ee+Child(ren	_____ +	_____ =	_____ X	_____ =	_____
Ee+Family	_____ +	_____ =	_____ X	_____ =	_____
		First month premium	Total		

DELTA DENTAL®
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Coverage Options

Benefit Level: (Class I/Class II/Class III) 100/100/50 100/80/50 80/80/50

Annual Maximum: \$1,000 \$1,500 \$2,000

Annual Deductible: \$0 \$25 \$50 \$75

Orthodontics (Minimum 10 Full-Time Employees):

Yes No
 50% to \$1,000 Lifetime Maximum 50% to \$1,500 Lifetime Maximum 50% to \$2,000 Lifetime Maximum

Waiting Periods (Class II, 6 months / Class III, 12 months):

Yes No

Smoking Cessation Discount (group agrees to offer smoking cessation plans and/or distribute smoking cessation brochures):

Yes No

Group declines coverage for non-state registered domestic partnerships:

Declined

Dependent Age Limit:

Eligible dependents are covered through the age of 24

Insurance Producer Information

Insurance Producer:			
Insurance Producer Company Name			
Address:			
City, State, Zip:			
Phone Number:	()	Fax Number::	()
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.

I certify my understanding that all employee enrollment and maintenance will be self-processed by on-line enrollment.

_____ (Signature)
Company Representative/Title (Please Print)

Date Signed _____



Washington Dental Service

Online Enrollment Master Application

Washington Dental Service offers the ability to submit enrollment and most census changes in “real time” through the Washington Dental Service secured Web site. This process is mandatory for the SimpleChoice™ plans.

Group and Benefit Administrator Information

List name and e-mail address for each person in your group who should be able to access online enrollment. One person must be designated as the lead benefit administrator.

Group Name _____
 Group Number _____
 Phone Number _____

Benefit Administrator	Name	Email	Group Level Access (Includes all subgroups)	If specific subgroups, then list them
Lead Benefit Administrator			Yes <input type="checkbox"/> No <input type="checkbox"/>	
Additional Benefit Administrator			Yes <input type="checkbox"/> No <input type="checkbox"/>	
Additional Benefit Administrator			Yes <input type="checkbox"/> No <input type="checkbox"/>	
Insurance Producer or TPA Name and Firm. <i>(If an insurance producer will be using the application, fill out this area and the additional information below.)</i>			Yes <input type="checkbox"/> No <input type="checkbox"/>	

*** Remember to notify WDS if any changes occur in user privileges.**

Complete the following if you wish to authorize your Insurance producer to access online enrollment.

Insurance Producer Name _____
 Phone Number _____
 Insurance Producer License Number _____
 Insurance Producer Cross Reference Number
 (WDS Use Only) _____

Online enrollment is provided via a secured Web site. Washington Dental Service allows authorized users access to this site for these identified purposes only — to submit accurate, timely and complete enrollment information, and to review available reports.

Accounts will be established, and initial passwords assigned, by Washington Dental Service for each benefit administrator ("user"). Each user should change this initial password during his or her first session. Users may also change passwords at any time. If a user forgets his or her password, call Washington Dental Service at 1-888-286-9105.

In consideration of Washington Dental Service's grant of access to the Web site, the group, acting through the undersigned representative, warrants that:

1. The users identified in this application are authorized to submit enrollment information and view eligibility reports.
2. Washington Dental Service has the right to rely on electronically submitted enrollment information to the same extent, and in the same way, as it would if the information were submitted by other means.
3. **The user(s) in this application agree to submit all census information solely via the Online Enrollment application – including renewal, or open enrollment information.**
4. The user(s) named in this application agree that the current census provided by WDS for review is correct, and that all necessary changes have been made, prior to receiving access to the Online Enrollment application.
5. The group will take reasonable and prudent measures to prevent unauthorized access to the Web site by someone acting or purporting to act on the group's behalf. This includes all required steps needed to comply with the HIPAA privacy and security regulations. (see <http://www.hhs.gov/ocr/hipaa/>)
6. A group may have multiple authorized users, but each user MUST have his or her own account (identifying login and password). Group agrees not to allow "shared" accounts and to take any necessary steps to prevent unauthorized use of accounts.
7. The above-named users will be allowed to access only the above-specified groups and subgroups.
8. Washington Dental Service may avail itself of any remedy under the law or the group contract, including cancellation of the group contract, if any user who is authorized to act on the group's behalf accesses the Web site for any purpose other than specified herein.
9. **The user(s) identified in this application agree to remit payment in the exact amount for which they are invoiced, and within the allowed time period given for payment. Consistent failure to "pay-as-billed" or remitting payment outside the allowed time period may result in the removal of the users' access to WDS Online Enrollment.**
10. Either the group or Washington Dental Service may revoke any user's access to the Web site at any time with or without cause. The revoking entity will promptly notify the other of the revocation by e-mail, fax, or mail.

Authorized Signature

Date

Printed Name

Title