

**DELTA DENTAL®**  
**Washington Dental Service**

Washington Dental Service is a member of the Delta Dental Plans Association  
 9706 4th Ave NE Seattle, WA 98115-2157

**Enrollment Form**

New  Change  Open Enrollment  COBRA  Reinstate  Other (Check One)

Employer or Group Name	Group Number	Subgroup	Hire Date	Effective Date	
Social Security Number	First Name	Middle Initial	Last Name	Birthdate	Gender
Address		City	State	Zip	
Phone Number		Email Address			

**Dependents**

Please list all dependents to be covered:

First Name	Middle Initial	Last Name	Birthdate	Gender	Add/Remove	Dependent Over Limiting Age Verification*	Coordination of Benefits	
Spouse or Domestic Partner**				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dependent				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>	<input type="checkbox"/> FT Student <input type="checkbox"/> Incapacitated*** <input type="checkbox"/> Primarily Dependent	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dependent				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>	<input type="checkbox"/> FT Student <input type="checkbox"/> Incapacitated*** <input type="checkbox"/> Primarily Dependent	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dependent				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>	<input type="checkbox"/> FT Student <input type="checkbox"/> Incapacitated*** <input type="checkbox"/> Primarily Dependent	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dependent				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>	<input type="checkbox"/> FT Student <input type="checkbox"/> Incapacitated*** <input type="checkbox"/> Primarily Dependent	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**Coordination of Benefits**

Do any of your dependents have other dental coverage? Yes  No  If yes, please complete the section below.

Employer Group Number and Name	Effective Date				
Name and Address of Other Insurance Carrier					
Social Security Number	First Name	Middle Initial	Last Name	Birthdate	Gender

**COBRA Enrollment Only**

Indicate Qualifying Date
Indicate Qualifying Event <input type="checkbox"/> Termination <input type="checkbox"/> Reduction in Hours <input type="checkbox"/> Divorce <input type="checkbox"/> Widowed/Surviving Dependent <input type="checkbox"/> Dependent Child No Longer Eligible <input type="checkbox"/> Other

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 (R.C.W. 48.135.080).

\*The minimum limiting age is as defined by state and federal regulations.

\*\*Domestic partners include state-registered partnerships and/or other domestic partners if specifically covered by group.

\*\*\*Documentation is required (pursuant to R.C.W. 48.44.210). To download the proof of incapacity and dependency form, visit the Washington Dental Service Web site at [www.DeltaDentalWA.com/forms](http://www.DeltaDentalWA.com/forms).

Signature \_\_\_\_\_ Date \_\_\_\_\_