

**Group Information**

New Group # (Internal Use Only)

Group Name	Phone Number	Fax Number	
Street Address	City	State	Zip Code
Billing Address (if different from street address)	City	State	Zip Code
Company Representative (name)	Title		
Company Representative E-mail Address			
Billing Contact Name (if different)	Title		
Billing Contact E-mail Address			
Type/Nature of Business			

**Employee Eligibility**

Effective Date (Contract period will be 12 continuous months from the effective date, the Benefit Period will be the effective date through December 31st and January through December thereafter.)  _____ / _____ / _____ mo          day          year	Number of Total Employees  _____	Number of Enrolled Employees  _____
Coverage for non-state registered domestic partnerships <input type="checkbox"/> Yes <input type="checkbox"/> No	New Employee Waiting Period (check one) First of the month following: <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 days _____ months after date of hire (A minimum of 80 hours per month constitutes full-time employment.)	

**Contribution / Participation**

Employer Contribution	Employee Participation		Dependent Participation
	Groups 5 — 9	Groups 10 — 99	
_____ % Employer Contribution (Must be a minimum of 50% or more employer-paid.)	<input type="checkbox"/> 100% enrollment of all eligible employees <input type="checkbox"/> Tied to medical	<input type="checkbox"/> 75% enrollment of eligible employees <input type="checkbox"/> Tied to medical	_____ % (Minimum 50% or more enrollment of eligible dependents) <input type="checkbox"/> Tied to medical


**Voluntary PPO Plan Only**

Employer Contribution	Employee Participation	Dependent Participation
<input type="checkbox"/> No Minimum	<input type="checkbox"/> Five (5) enrolled employees or 20% of all eligible employees, whichever is greater	<input type="checkbox"/> No Minimum

Plan Section

Premier Plans					
		Annual Maximum	Annual Deductible	Orthodontics (Minimum group size 10)	Optional Coverage
Delta Dental Premier Plans*	<input type="checkbox"/> 100/90/60 <input type="checkbox"/> 100/90/50 <input type="checkbox"/> 100/80/50 <input type="checkbox"/> 80/80/50	<input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000	<input type="checkbox"/> \$0/\$0 <input type="checkbox"/> \$25/\$75 <input type="checkbox"/> \$50/\$150 <input type="checkbox"/> \$75/\$225 <input type="checkbox"/> \$100/\$300	<input type="checkbox"/> Children Only <input type="checkbox"/> Adults & Children	Lifetime Maximum <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 Posterior Composite Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No

PPO Plans					
		Annual Maximum	Annual Deductible	Orthodontics (Minimum group size 10)	Optional Coverage
Delta Dental PPO Plans	<input type="checkbox"/> 100/90/60 – 100/80/60 <input type="checkbox"/> 100/90/50 – 100/80/50 <input type="checkbox"/> 100/80/50 – 80/70/40 <input type="checkbox"/> 80/80/50 – 70/70/40	<input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000	<input type="checkbox"/> \$0/\$0 <input type="checkbox"/> \$25/\$75 <input type="checkbox"/> \$50/\$150 <input type="checkbox"/> \$75/\$225 <input type="checkbox"/> \$100/\$300	<input type="checkbox"/> Children Only <input type="checkbox"/> Adults & Children	Lifetime Maximum <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 Posterior Composite Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No
Delta Dental PPO Voluntary Plans	<input type="checkbox"/> 100/80/50 – 80/70/40 Enhanced (With periodontics and endodontics in Class II) <input type="checkbox"/> 100/80/50 – 80/70/40 Standard (With periodontics and endodontics in Class III) <input type="checkbox"/> 80/80/50 – 70/70/40 Enhanced (With periodontics and endodontics in Class II) <input type="checkbox"/> 80/80/50 – 70/70/40 Standard (With periodontics and endodontics in Class III)	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500	<input type="checkbox"/> \$50/\$150 <input type="checkbox"/> \$75/\$225	<input type="checkbox"/> Children Only	Lifetime Maximum <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 Posterior Composite Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Delta Dental PPO Value Plan <input type="checkbox"/> Delta Dental PPO Basic Plan	<input type="checkbox"/> 100/90/60 – 100/80/60 <input type="checkbox"/> 100/90/50 – 100/80/50 <input type="checkbox"/> 100/80/50 – 80/70/40 <input type="checkbox"/> 80/80/50 – 70/70/40	<input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000	<input type="checkbox"/> \$0/\$0 <input type="checkbox"/> \$25/\$75 <input type="checkbox"/> \$50/\$150 <input type="checkbox"/> \$75/\$225 <input type="checkbox"/> \$100/\$300	<input type="checkbox"/> Children Only <input type="checkbox"/> Adults & Children	Lifetime Maximum <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 Posterior Composite Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No


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## SimpleChoice Plan

		Annual Maximum	Annual Deductible	Orthodontics (Minimum group size 10)	Optional Coverage	
SimpleChoice™	<input type="checkbox"/> 100/100/50 <input type="checkbox"/> 100/80/50 <input type="checkbox"/> 80/80/50	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$0/\$0 <input type="checkbox"/> \$25/\$75 <input type="checkbox"/> \$50/\$150 <input type="checkbox"/> \$75/\$225	<input type="checkbox"/> Adults & Children	Lifetime Maximum <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	Waiting Periods <input type="checkbox"/> Yes <input type="checkbox"/> No

## Rates

	Plan Rates		Ortho Rates from Rider		Optional Rider Rates		Rates Sub-Total		Number of Employees		Premium
Employee		+		+		=		x		=	
Employee + Spouse*		+		+		=		x		=	
Employee + Child(ren)*		+		+		=		x		=	
Employee + Family*		+		+		=		x		=	
*Spouse includes state registered domestic partners.							First Month's Premium	Total =			

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## Insurance Producer Information

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Insurance Producer	Phone Number		
Insurance Producer Company Name	Fax Number		
Insurance Producer Address	City	State	Zip Code
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. Washington Dental Service reserves the right to audit any information provided herein for compliance and accuracy.

\_\_\_\_\_  
Company Representative/Title (Please Print)      Signature      Date

\_\_\_\_\_  
Insurance Producer/Title (Please Print)      Signature      Date



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

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