

P.O. Box 75983
 Seattle WA 98175-0983
 (206) 528-5335 or (800) 572-7835 x 5335

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% 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% 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)	
Delta Dental Premier Plans®	<input type="checkbox"/> 100/80/50 (Prime Care) <input type="checkbox"/> 80/80/50 (StandardCare)	<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"/> Children Only <input type="checkbox"/> Adults & Children	Lifetime Maximum <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000
Delta Dental Premier® Incentive Plans	<input type="checkbox"/> Class I & II 70-100/50 (IncentiveCare) Incentive Takeover Plan (80% for Incentive groups only) <input type="checkbox"/> Yes <input type="checkbox"/> No	<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"/> Children Only <input type="checkbox"/> Adults & Children	Lifetime Maximum <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000

PPO Plans						
		Annual Maximum	Annual Deductible	Orthodontics (Minimum group size 10)	Optional Coverage	
Delta Dental PPO Plans	<input type="checkbox"/> 100/80/50 – 80/70/40 (PreferredCare) <input type="checkbox"/> 100/90/50 – 100/80/50 (PreferredCare Enhanced) <input type="checkbox"/> 80/80/50 – 70/70/40 (PreferredCare II) <input type="checkbox"/> Class I & II 70-100/50 – 60-90/40 (Preferred IncentiveCare) Incentive Takeover Plan (80% for Incentive groups only) <input type="checkbox"/> Yes <input type="checkbox"/> No	<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"/> 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 Core-Plus Plans	<input type="checkbox"/> 80/50/30 – 60/40/20 Enhanced (With periodontics and endodontics in Class II) <input type="checkbox"/> 80/50/30 – 60/40/20 Standard (With periodontics and endodontics in Class III)	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<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	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

PPO Plans (Continued)

<input type="checkbox"/> Delta Dental PPO Value Plan <i>(Not available with DeltaCare Dual Choice Plan)</i>	<input type="checkbox"/> 80/80/50 – 70/70/40	<input type="checkbox"/> \$750	<input type="checkbox"/> \$0/\$0	<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
	<input type="checkbox"/> 100/80/50 – 80/70/40	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$25/\$75			
	<input type="checkbox"/> 100/90/60 – 100/80/60	<input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000	<input type="checkbox"/> \$50/\$150 <input type="checkbox"/> \$75/\$225 <input type="checkbox"/> \$100/\$300			

DeltaCare Plans

		Copay	Orthodontics <i>(Minimum group size 10)</i>
<input type="checkbox"/> DeltaCare – Stand Alone <input type="checkbox"/> DeltaCare – Dual Choice	<input type="checkbox"/> DeltaCare Charter 10	<input type="checkbox"/> \$0 <input type="checkbox"/> \$10	<input type="checkbox"/> Children Only <input type="checkbox"/> Adults & Children
	<input type="checkbox"/> DeltaCare Standard 10		
<input type="checkbox"/> DeltaCare Standard 30			

SimpleChoice Plan

		Annual Maximum	Annual Deductible	Orthodontics <i>(Minimum group size 10)</i>	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"/> \$0/\$0 <input type="checkbox"/> \$25/\$75 <input type="checkbox"/> \$50/\$150 <input type="checkbox"/> \$75/\$225	<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	Smoking Education Discount <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> \$1,500				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<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		=	
							First Month's Premium	Total	=		

*Spouse includes state registered domestic partners.

Insurance Producer Information

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

 **DELTA DENTAL[®]**
Washington Dental Service
Washington Dental Service is a member of the Delta Dental Plans Association
P.O. Box 75983
Seattle WA 98175-0983
(206) 528-5335 or (800) 572-7835 x 5335