



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

WDS Small Business Plans

New Change Open Enrollment COBRA Reinstatement 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*
Spouse or Domestic Partner**				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>	
Dependent				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>	Incapacitated*** <input type="checkbox"/>
Dependent				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>	Incapacitated*** <input type="checkbox"/>
Dependent				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>	Incapacitated*** <input type="checkbox"/>
Dependent				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>	Incapacitated*** <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

Coverage Buy-Up (If Applicable)

Check One

- I choose optional buy-up coverage I decline optional buy-up coverage

Waiver Dental Coverage

I certify that I have been advised of the features and benefits of the dental plan offered to me through my employer and after due consideration, I have chosen:

- Not to enroll my spouse in the group dental plan being offered by my employer.
- Not to enroll my children in the group dental plan being offered by my employer
- Not to enroll myself and my dependents in the group dental plan being offered by my employer. I understand that by taking this action, I waive all benefits payable thereunder from myself and/or my dependents.

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.

Signature _____

Date _____