DELTA DENTAL | Delta Dental of Washington

Enrollment Form

Small Group Dental and Vision Coverage

400 Fairview Ave N Suite 800
Seattle WA 98109-5371
(800) 554-1907

☐ **New** ☐ **Open Enrollment** ☐ **COBRA** ☐ **Reinstate** ☐ **Change** | ***Description of Changes:*** _____

☐ **Waive coverage (*select any that apply*):** ☐ Myself and all dependents ☐ Spouse/domestic partner* ☐ Dependent children**

By waiving coverage, you understand and acknowledge that you and/or your dependents will not be eligible for the features and benefits of the dental plan offered to you by your employer.

Please complete and return this form to enroll in the dental and vision benefits plan(s) offered by your employer. See your Benefits Administrator for information regarding the dental and vision (if applicable) plans available to you.

Subscriber Information *(please complete all fields)*

Employer or Group Name		Group-Subgroup Number	Effective Date	
First Name	Middle Initial	Last Name	Social Security Number	Birthdate
Address		City	State	ZIP Code
Email		Phone Number Is this a mobile number? ☐ Yes ☐ No		
Dental Coverage: ☐ Add ☐ Remove		**Vision Coverage:** ☐ Add ☐ Remove		

By providing your email address and phone number, you automatically agree to receive electronic communications regarding your Plan and benefits.

For information on how to opt-out of electronic communications, please review our Privacy Policy at ***www.DeltaDentalWA.com***

Dependent Information

Please list all dependents to be covered (please attach a separate page if you are unable to list all dependents):

Name (First, Middle Initial, Last)	Relationship	Birthdate	Add/Remove
	☐ Spouse or Domestic Partner* ☐ Dependent Child**		☐Add ☐Remove
	Dependent Child**		☐Add ☐Remove
	Dependent Child**		☐Add ☐Remove
	Dependent Child**		☐Add ☐Remove
	Dependent Child**		☐Add ☐Remove

Are any of your dependents being covered past the limiting age due to incapacitation? ☐Yes*** ☐No

Coordination of Benefits

Please complete this section if you or your dependents have any other dental coverage.

Please check all that other coverage applies to: ☐Self ☐All Dependents with other coverage ☐Dependent(s) (Specify) _____				
Employer Group Number and Name			Effective Date	
Name and Address of Insurance Carrier				
First Name	Middle Initial	Last Name	Social Security Number	Birthdate

For additional COB information please attach a separate page or call (800) 554-1907.

This Section is for "Delta Dental PPO℠ – Core/Buy-up" Plan Enrollment Only

If you are enrolling in the **Delta Dental PPO – Core/Buy-up** Plan, please select your coverage option below.

☐Core ☐Buy-up	*Please talk to your Benefits Administrator or review a copy of a Plan Overview Page for information regarding your benefit specific coverage options.*

This section for COBRA Enrollment Only

Indicate Qualifying Date:
Indicate Qualifying Event ☐Termination ☐Reduction in Hours ☐Divorce ☐Dissolution of Domestic Partnership ☐Widowed/Surviving Dependent ☐Dependent Child No longer Eligible ☐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).

*Domestic partners include state-registered partnerships and any other domestic partners that are covered by group.

**The minimum limiting age is through age 25 for all dependent children; coverage shall not terminate for children over the age of 25 who are both:

(1) incapable of self-sustaining employment by reason of developmental or physical disability
(2) chiefly dependent upon the employee or member for support and maintenance

***Documentation is required to show that such child continues to be incapable of self-sustaining employment by reason of developmental or physical disability and that such child is chiefly dependent upon the employee or member for support and maintenance. For more information, please call us at 1-800-554-1907.

Signature _____ Date _____