DELTA DENTAL® Delta Dental of Washington

DeltaCare®
Administered by Delta Dental of Washington

Application for VSP® Vision and DeltaCare® Dental Coverage

400 Fairview Ave N Suite 800
Seattle, WA 98109-5371
(877) 404-0364

Group Information

Group Name	Phone Number	Fax Number	
Address	City	State	ZIP Code
Representative Name	Title		
Tax ID Number (TIN)	NAICS Code (6 Digit)		
Email			

Billing Information (please complete if different than Group Information)

Company Name	Phone Number	Fax Number	
Billing Address	City	State	ZIP Code
Billing Representative Name	Title		
Email			

Employee Eligibility

New Employee Waiting Period *(check one)*: ☐ Flexible *-or-* ☐ First day of the month following: ☐ 30 ☐ 60 ☐ 90 days *-or-* ☐ _____ days following date of hire	Total Number of Eligible Employees:	Total Number of Enrolled Employees:
Domestic partner coverage?: ☐ Any Domestic Partners ☐ Registered Domestic Partners		

Dental Coverage Selections

Participation

Employee Participation (select one)	Dependent Participation
☐ 75% enrollment of all Eligible Employees ☐ 100% enrollment of all Eligible Employees	No Minimum

Program Description

Contract Effective Date: _____ Contract period will be 12 continuous months from the effective date.

The Benefit Period will be the Contract Effective Date through December 31st and January through December thereafter.

DeltaCare® Plans for 51+ Employees

Plan Name	TMJ Coverage	Ortho Coverage	Implant Coverage
☐ DeltaCare® Peak Plan	Surgical & Non-Surgical 50% to $1,000 Annually with $5,000 lifetime maximum	☐ No Coverage ☐ Peak Ortho Plan A: $1600 children/$2000 adults	☐ No Coverage ☐ Implant Coverage
☐ DeltaCare® Base Plan	Surgical & Non-Surgical 50% to $1,000 Annually with $5,000 lifetime maximum	☐ No Coverage ☐ Base Ortho Plan A: $1600 children/$2000 adults	☐ No Coverage ☐ Implant Coverage

Vision Coverage Selections

If your group would like to enroll in a vision plan, please complete the selections below.

Participation

Employee Participation (select one)	Dependent Participation (select one)
☐ 50% Employee Enrollment ☐ Voluntary	☐ 50% Dependent Enrollment ☐ Voluntary

Plan Selection

VSP Plan Options – Administered by Vision Service Plan (VSP) – *3333 Quality Drive Rancho Cordova, CA 95670*					
Plan Name	**Copays**	**Exam**	**Frames**	**Lenses**	**LightCare™****
☐ DeltaVision® 150 LC	$10 Exam $25 Materials (Lenses/Frames)	1 x every 12 months	$150 Plan Allowance 1 x every 24 months	1 x every 12 months	Included
☐ DeltaVision® 200 LC	$10 Exam $25 Materials (Lenses/Frames)	1 x every 12 months	$200 Plan Allowance 1 x every 24 months	1 x every 12 months	Included
☐ DeltaVision® 150 Plus EasyOptions*	$10 Exam $10 Materials (Lenses/Frames)	1 x every 12 months	$150 Plan Allowance (Plus 1 x every 12 months	1 x every 12 months	Included
☐ DeltaVision® 200 Plus EasyOptions*	$10 Exam $10 Materials (Lenses/Frames)	1 x every 12 months	$200 Plan Allowance 1 x every 12 months	1 x every 12 months	Included

*EasyOptions is a customization feature that allows each member the option to choose one of the following upgrades at the time of service (when seen by a VSP Network Doctor): additional frame allowance, additional elective contact lens allowance, or a lens enhancement (progressive lenses, photochromic (light reactive) coating, or anti-glare coating).

**LightCare is a customization feature that allows each member the option to use their frame and lens allowance for non-prescription sunglasses or non-prescription blue-light-filtering glasses, in place of prescription glasses (lenses and frames).

Rates

The dental commission percentage chosen below will be incorporated into the dental Plan rates for groups of 51+ employees and will be included in the final Premium box located below.

Please note: This does not apply to vision.

☐ 0% Dental Plan Commission

☐ 3% Dental Plan Commission

☐ 5% Dental Plan Commission

	Dental Plan Rates		Vision Plan Rates		Ortho Rates		Implant Rates		Rates Sub-Total		Number of Employees		Premium
Employee		+		+		+		=		x		=	
Employee + Spouse****		+		+		+		=		x		=	
Employee + Child(ren)		+		+		+		=		x		=	
Employee + Family***		+		+		+		=		x		=	
***Employee and Family means an Employee and any dependents.									Total	=			

****In Washington State, references to Married or Spouse apply equally to same-sex and opposite-sex spouse and to both registered and un-registered domestic partnerships.

Insurance Producer Information

Producer Name	License Number		
Company Name	Phone Number	Fax Number	
Address	City	State	ZIP Code
Email			

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. Delta Dental of Washington 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