



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 ( <i>check one</i> ):  <input type="checkbox"/> Flexible- <i>or</i> - <input type="checkbox"/> First day of the month following: <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 days - <i>or</i> - <input type="checkbox"/> _____ days following date of hire - <i>or</i> - <input type="checkbox"/> Date of Hire	Total Number of Eligible Employees:	Total Number of Enrolled Employees:
	Domestic partner coverage? <input type="checkbox"/> Any Domestic Partner - <i>or</i> - <input type="checkbox"/> Registered Domestic Partners	Is dual coverage allowed? <input type="checkbox"/> Yes <input type="checkbox"/> No  <i>This is when a member is covered under two plans by the same employer.</i>

## Dental Coverage Selections

## Participation

Employee Participation (select one)	Dependent Participation (select one)
<input type="checkbox"/> _____ % Employee Enrollment <input type="checkbox"/> Tied to Medical <input type="checkbox"/> Voluntary	<input type="checkbox"/> _____ % Dependent Enrollment <input type="checkbox"/> Tied to Medical <input type="checkbox"/> Voluntary

## Plan Description

Requested Effective Date: _____		Contract Term: _____ to _____	
Benefit Period: <input type="checkbox"/> Calendar year <input type="checkbox"/> Contract Term		Plan Type: <input type="checkbox"/> Local <input type="checkbox"/> National	
Benefit Coverage Levels	In-Network Delta Dental PPO Dentist	Out-of-Network Non-PPO Dentist	Out-of-State Dentist (Local Plans Only)
Class I	_____ %	_____ %	_____ %
Class II	_____ %	_____ %	_____ %
Class III	_____ %	_____ %	_____ %
Orthodontic Benefits	_____ %	_____ %	_____ %
Annual Maximum	\$ _____	\$ _____	\$ _____
<b>Diagnostic/Preventive Waiver:</b> <input type="checkbox"/> Yes (Class I covered dental benefits do not accrue towards the plan maximum) <input type="checkbox"/> No			
<b>Annual Deductible applies to:</b> <input type="checkbox"/> In-Network & Out-of-Network <input type="checkbox"/> Out-of-Network Only <input type="checkbox"/> In-Network Only <input type="checkbox"/> No Deductible Amount – In-Network: Individual \$ _____ Family \$ _____ Amount – Out-of-Network: Individual \$ _____ Family \$ _____ <b>Deductible Waived On:</b> <input type="checkbox"/> Class I <input type="checkbox"/> Class II <input type="checkbox"/> Class III <input type="checkbox"/> Orthodontics <input type="checkbox"/> Accidental Injury <input type="checkbox"/> Other _____			
Orthodontic Lifetime Maximum: \$ _____		Coverage Type: <input type="checkbox"/> Children Only <input type="checkbox"/> Adult & Children	
Temporomandibular (TMJ) Coverage Surgical (paid at 50% to \$1,000 annual with \$5,000 lifetime maximum): <input type="checkbox"/> Yes <input type="checkbox"/> No			
Coordination of Benefits: <input type="checkbox"/> Standard (birthday rule) <input type="checkbox"/> Non-duplication of benefits (Self-Funded Groups Only)			
Dependent Children Covered to Age: _____ (per RCW 48.44.215 the minimum is through age 25)			
Other Specific Benefits: _____			

**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)
<input type="checkbox"/> 50% Employee Enrollment <input type="checkbox"/> Voluntary	<input type="checkbox"/> 50% Dependent Enrollment <input type="checkbox"/> 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™**
<input type="checkbox"/> 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
<input type="checkbox"/> 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
<input type="checkbox"/> 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
<input type="checkbox"/> 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

Rate Tiers	Dental Rates	Vision Rates
Employee Only	\$	\$
Employee + Spouse***	\$	\$
Employee + Child(ren)	\$	\$
Employee + Spouse*** + two (2) or more Children	\$	\$
<b>Other Rate Tiers (if applicable)</b>		
Employee + 1	\$	\$
Employee + 2	\$	\$
Composite	\$	\$
ASC Fee	\$	\$

\*\*\*In Washington State, references to Married or Spouse apply equally to same-sex and opposite-sex spouse and to both registered and unregistered 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