DELTA DENTAL® Delta Dental of Washington

Application

Large Group Coverage - Dental
Delta Dental PPO™

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):*	Total Number of Eligible Employees:	Total Number of Enrolled Employees:
☐ Flexible-*or*- ☐ First day of the month following: ☐ 30 ☐ 60 ☐ 90 days -*or*- ☐_____days following date of hire -*or*- ☐ Date of Hire	Domestic partner coverage? ☐ Any Domestic Partners - *or* - ☐ Registered Domestic Partners	Is dual coverage allowed? ☐ Yes ☐ No *This is when a member is covered under two plans by the same employer.*

Participation

Employee Participation (select one)	Dependent Participation (select one)
☐ _____% Employee Enrollment ☐ Tied to Medical ☐ Voluntary	☐ _____% Dependent Enrollment ☐ Tied to Medical ☐ Voluntary

Rates

Rates		Other Rate Tiers (if applicable)	
Employee Only	$	Employee + 1	$
Employee + Spouse*	$	Employee + 2	$
Employee + Child(ren)	$	Composite	$
Employee + Spouse* + two (2) or more Children	$	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.

Plan Description

Requested Effective Date: _____ **Contract Term:** _____ to _____

Benefit Period: ☐ Calendar year ☐ Contract Term **Plan Type:** ☐ Local ☐ 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	$_____	$_____	$_____

Diagnostic/Preventive Waiver: ☐ Yes (Class I covered dental benefits do not accrue towards the plan maximum) ☐ No

Annual Deductible applies to: ☐ In-Network & Out-of-Network ☐ Out-of-Network Only ☐ In-Network Only ☐ No Deductible

Amount – In-Network: Individual $ _____ Family $ _____

Amount – Out-of-Network: Individual $ _____ Family $ _____

Deductible Waived On: ☐ Class I ☐ Class II ☐ Class III ☐ Orthodontics ☐ Accidental Injury ☐ Other_____

Orthodontic Lifetime Maximum: $_____ Coverage Type: ☐ Children Only ☐ Adult & Children

Temporomandibular (TMJ) Coverage Surgical (paid at 50% to $1,000 annual with $5,000 lifetime maximum): ☐ Yes ☐ No

Coordination of Benefits: ☐ Standard (birthday rule) ☐ 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:_____

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