

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 Partners - <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>

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

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: <input type="checkbox"/> Calendar year <input type="checkbox"/> Contract Term		Plan Type: <input type="checkbox"/> Local <input type="checkbox"/> National	
Variable Plan Maximum			
Initial Annual Maximum	\$	Highest Annual Maximum	\$
Incremental Amount Increase	\$	Incremental Amount Decrease	\$
Diagnostic/Preventive Waiver: <input type="checkbox"/> Yes (Class I covered dental benefits do not accrue towards the plan maximum) <input type="checkbox"/> No			
Variable Services: <input type="checkbox"/> Healthy Checkups <input type="checkbox"/> All Class I		Network Selection: <input type="checkbox"/> PPO Only <input type="checkbox"/> PPO and Premier <input type="checkbox"/> PPO, Premier and Non-Par	
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 Deductible applies to: <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 \$ _____ Deductible Waived On: <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: _____			

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