DELTA DENTAL® Delta Dental of Washington

Additional Diagnosis Specific Benefit – Application Form

TotalHealth Wellness Program for Large Employer Groups

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

Your Plan offers additional cleaning benefits for you and your enrolled dependents if you have been diagnosed with certain qualifying medical conditions that impact your oral health*.

Please use this form to self-report qualifying medical conditions for you and your enrolled dependents if you wish to receive additional covered services.

Subscriber Information *(*Required fields)*

Name (First, Middle Initial, Last) *	Birthdate *	Member ID Number
Employer or Group Name *	Group Number	Subgroup Number

Applicant Information *(*Required fields)*

Name (First, Middle Initial, Last) *	Birthdate *	Relationship to Subscriber *

Qualifying Medical Conditions

- Alzheimer's
- Amyotrophic lateral sclerosis (ALS)
- Cancer
- Chronic Kidney Disease
- Dementia
- Diabetes
- Heart disease
- Huntington's disease
- Joint Replacement
- Lupus
- Oral Cancer
- Opioid misuse and addiction
- Other auto immune diseases
- Other neurological diseases
- Parkinson's disease
- Periodontal disease
- Pregnancy
- Rheumatoid arthritis
- Stroke
- Sjögren's syndrome

Member(s) with Associated Condition

Please use the table below to report members who have one or more of the qualifying medical conditions listed above (please attach a separate page if you are unable to list all information in table below).

Name *(First, Middle Initial, Last)*	**Relationship to Subscriber** *(Self, Spouse/DP**, Dependent Child)*	**Birthdate**	**Qualifying Medical Condition(s)** *(From list above)*

*Limitations apply. Refer to benefit booklet for full plan and benefit details.

**Domestic partners are treated the same as a spouse. This includes state-registered partnerships and/or other domestic partners if specifically covered by group.

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).

I understand by submitting this form, I am authorizing and providing consent for DDWA to receive my (or my dependent's) medical information in order to allow for additional covered dental services.

_____ _____
Printed Name Date

_____ _____
Signature Date

Please return completed form to:	Delta Dental of Washington P.O. Box 75983 Seattle, WA 98175-0983	**Or**	**Email:** webcs@deltadentalwa.com