



Delta Dental of Washington

DeltaCare®

Administered by Delta Dental of Washington

Application for DeltaCare® Dental Coverage

Seattle

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

Spokane

611 N Iron Bridge Way, Suite 200
Spokane, WA 99202-0626
(800) 564-8832

Group Information

Group # (Internal Use Only)

Group Name	Phone Number	Fax Number	
Address	City	State	ZIP Code
Representative Name	Title		
Email	NAICS Code (3-4 Digit)		

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

Effective date (Contract period will be 12 continuous months from the effective date, the Benefit Period will be the effective date through December 31st and January through December thereafter.) ____ / ____ / ____ month day year	Total Number of Eligible Employees:	Total Number of Enrolled Employees:
Coverage for non-state registered domestic partnerships <input type="checkbox"/> Yes <input type="checkbox"/> No	New Employee Waiting Period (<i>check one</i>) <input type="checkbox"/> Flexible -or- <input type="checkbox"/> First day of the month following: <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 days -or- <input type="checkbox"/> ____ days following date of hire.	

Participation

Employee Participation		Dependent Participation
<input type="checkbox"/> 50% enrollment of all Eligible Employees	<input type="checkbox"/> 75% enrollment of all Eligible Employees	<input type="checkbox"/> Minimum 50% enrollment of Eligible Dependents
<input type="checkbox"/> 100% enrollment of all Eligible Employees	<input type="checkbox"/> Tied to medical	<input type="checkbox"/> Tied to medical

Program Description

DeltaCare® Plans for 100+ Employees				
Plan Name	TMJ Coverage	Ortho Coverage		Implant Coverage
<input type="checkbox"/> DeltaCare® 10	<input type="checkbox"/> No Coverage <input type="checkbox"/> Surgical & Non-Surgical 50% to \$1,000 Annually with \$5,000 lifetime maximum	<input type="checkbox"/> No Coverage <input type="checkbox"/> Local Ortho Plan A \$1200 children/\$1600 adults <input type="checkbox"/> Local Ortho Plan B \$1600 children/\$2000 adults	<input type="checkbox"/> Child Only <input type="checkbox"/> Adult & Children	N/A
<input type="checkbox"/> DeltaCare® 30	<input type="checkbox"/> No Coverage <input type="checkbox"/> Surgical & Non-Surgical 50% to \$1,000 Annually with \$5,000 lifetime maximum	<input type="checkbox"/> No Coverage <input type="checkbox"/> Local Ortho Plan A \$1200 children/\$1600 adults <input type="checkbox"/> Local Ortho Plan B \$1600 children/\$2000 adults	<input type="checkbox"/> Child Only <input type="checkbox"/> Adult & Children	N/A
<input type="checkbox"/> DeltaCare® Charter 10	<input type="checkbox"/> No Coverage <input type="checkbox"/> Surgical & Non-Surgical 50% to \$1,000 Annually with \$5,000 lifetime maximum	<input type="checkbox"/> No Coverage <input type="checkbox"/> Charter Ortho Plan A: \$1600 children/\$2000 adults <input type="checkbox"/> Charter Ortho Plan B: \$2150 children/\$2350	<input type="checkbox"/> Child Only <input type="checkbox"/> Adult & Children	N/A
<input type="checkbox"/> DeltaCare® Peak Plan	Surgical & Non-Surgical 50% to \$1,000 Annually with \$5,000 lifetime maximum	<input type="checkbox"/> No Coverage <input type="checkbox"/> Peak Ortho Plan A: \$1600 children/\$2000 adults	Adult & Children	<input type="checkbox"/> No Coverage <input type="checkbox"/> Implant Coverage
<input type="checkbox"/> DeltaCare® Base Plan	Surgical & Non-Surgical 50% to \$1,000 Annually with \$5,000 lifetime maximum	<input type="checkbox"/> No Coverage <input type="checkbox"/> Base Ortho Plan A: \$1600 children/\$2000 adults	Adult & Children	<input type="checkbox"/> No Coverage <input type="checkbox"/> Implant Coverage
DeltaCare® Plans for Group with 51-99 Employees				
Plan Name	TMJ Coverage	Ortho Coverage		Implant Coverage
<input type="checkbox"/> DeltaCare® Charter 10	Surgical & Non-Surgical 50% to \$1,000 Annually with \$5,000 lifetime maximum	<input type="checkbox"/> No Coverage <input type="checkbox"/> Charter Ortho Plan A: \$1600 children/\$2000 adults	Adult & Children	N/A
<input type="checkbox"/> DeltaCare® Peak Plan	Surgical & Non-Surgical 50% to \$1,000 Annually with \$5,000 lifetime maximum	<input type="checkbox"/> No Coverage <input type="checkbox"/> Peak Ortho Plan A: \$1600 children/\$2000 adults	Adult & Children	<input type="checkbox"/> No Coverage <input type="checkbox"/> Implant Coverage
<input type="checkbox"/> DeltaCare® Base Plan	Surgical & Non-Surgical 50% to \$1,000 Annually with \$5,000 lifetime maximum	<input type="checkbox"/> No Coverage <input type="checkbox"/> Base Ortho Plan A: \$1600 children/\$2000 adults	Adult & Children	<input type="checkbox"/> No Coverage <input type="checkbox"/> Implant Coverage

Rates

Commission percentage chosen below will be incorporated into the Plan rates for groups of 100+ employees and will be included in the final Premium box located below.

☐ 0% Commission

☐ 3% Commission

☐ 5% Commission

	Plan Rates		Ortho Rates		TMJ 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