

Seattle

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

Spokane

611 North Iron Bridge Way, Suite 200
Spokane, WA 99202
(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	Nature of Business			

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

Contract Effective Date ____ / ____ / ____ month day year The Contract Term is the 12-month period beginning on the Effective Date.		Total Number of Eligible Employees:		
		Total Number of Enrolled Employees:		
Benefit Period The Benefit Period for all plans is the Effective Date through December 31st, thereafter January through December.				
Domestic Partners Covered (check one) <input type="checkbox"/> All domestic partners <input type="checkbox"/> State registered domestic partners only				

Contribution / Participation (All Plans EXCEPT the Voluntary Plan, see below for Voluntary Plan information)

Employee Participation			Dependent Participation
Groups 2 — 9	Groups 10 — 50	Groups 51 — 99	
<input type="checkbox"/> 100% enrollment of all Eligible Employees	<input type="checkbox"/> 75% enrollment of Eligible Employees	<input type="checkbox"/> Minimum 50% enrollment of Eligible Dependents	
<input type="checkbox"/> Tied to medical	<input type="checkbox"/> Tied to medical	<input type="checkbox"/> Tied to medical	

Plan Selection (All Plans EXCEPT PPO Voluntary Plan)

DeltaCare Plans			
Plan Name	TMJ Coverage	Orthodontic Coverage	Implant Coverage
<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"/> \$1,600 children/\$2,000 adults	<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"/> \$1,600 children/\$2,000 adults	<input type="checkbox"/> No Coverage <input type="checkbox"/> Implant Coverage

PPO Plans						
Plan Name	In-Network Coverage	Out-of-Network Coverage	Annual Maximum	Annual Deductible	Orthodontics (Minimum group size 10)	Ortho Lifetime Max
<input type="checkbox"/> Delta Dental PPO SM	<input type="checkbox"/> 100/90/60 100/80/60 <input type="checkbox"/> 100/90/50 100/80/50 <input type="checkbox"/> 100/80/50 80/70/40		<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$4,000	<input type="checkbox"/> \$0/\$0 <input type="checkbox"/> \$25/\$75 <input type="checkbox"/> \$50/\$150	<input type="checkbox"/> Children <input type="checkbox"/> Adults & Children <input type="checkbox"/> No Ortho	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000
<input type="checkbox"/> Delta Dental PPO SM - Core/Buy-up	<input type="checkbox"/> Core 80/50/0 Buy-up 100/80/50		\$750	\$50/\$150	<i>No Ortho Coverage</i>	
			\$2,000	\$50/\$150	<input type="checkbox"/> Adults & Children <input type="checkbox"/> No Ortho	\$1,500
	<input type="checkbox"/> Core 100/50/0 Buy-up 100/80/50		\$750	\$50/\$150	<i>No Ortho Coverage</i>	
			\$1,500	\$50/\$150	<input type="checkbox"/> Adults & Children <input type="checkbox"/> No Ortho	\$1,500
<input type="checkbox"/> Delta Dental PPO SM - Maximum Wellness	<input type="checkbox"/> 100/80/50 100/80/50		\$1,000 to \$1,500 (\$100 increments)	\$50/\$150	<input type="checkbox"/> Adults & Children <input type="checkbox"/> No Ortho	\$1,000
	<input type="checkbox"/> 100/80/50 100/80/50		\$2,000 to \$2,500 (\$100 increments)	\$50/\$150	<input type="checkbox"/> Adults & Children <input type="checkbox"/> No Ortho	\$1,500

Plan Selection (PPO Voluntary Plan Only)

PPO Voluntary Plans						
Plan Name	In-Network Coverage	Out-of-Network Coverage	Annual Maximum	Annual Deductible	Orthodontics (Minimum group size 10)	Ortho Lifetime Max
<input type="checkbox"/> Delta Dental PPO SM – Voluntary Enhanced	<input type="checkbox"/> 100/90/50 100/80/50 <input type="checkbox"/> 100/80/50 80/70/40		<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$0/\$0 <input type="checkbox"/> \$25/\$75 <input type="checkbox"/> \$50/\$150	<input type="checkbox"/> Children <input type="checkbox"/> Adults & Children <input type="checkbox"/> No Ortho	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$3,000
<input type="checkbox"/> Delta Dental PPO SM – Voluntary Standard	<input type="checkbox"/> 100/80/50 80/70/40		<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$0/\$0 <input type="checkbox"/> \$25/\$75 <input type="checkbox"/> \$50/\$150	<input type="checkbox"/> Children <input type="checkbox"/> Adults & Children <input type="checkbox"/> No Ortho	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500
Employer Contribution		Employee Participation			Dependent Participation	
No Minimum		Two (2) Enrolled Employees or 20% of all Eligible Employees, whichever is greater			No Minimum	

Optional Vision Plan Selection (only available in addition to the selection of a dental plan)

VSP Plan Options				
Plan Name	Copays	Exam	Frames	Lenses
<input type="checkbox"/> DeltaVision® - 150	\$10 Exam \$25 Materials (Lenses/Frames)	1 x every 12 months	1 x every 24 months	1 x every 12 months
<input type="checkbox"/> DeltaVision® - 150 Plus	\$10 Exam \$10 Materials (Lenses/Frames)	1 x every 12 months	1x every 12 months	1 x every 12 months

Rates

	Plan Rates		PPO Buy-up		Optional Vision			Number of Employees		Premium
Employee		+		+		=		x	=	
Employee + Spouse*		+		+		=		x	=	
Employee + Child(ren)		+		+		=		x	=	
Employee + Spouse + Child(ren)		+		+		=		x	=	

*In Washington State, references to 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