DELTA DENTAL® Delta Dental of Washington

Application

Large Group Coverage
Delta Dental Premier

Seattle
400 Fairview Ave, 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: _____ / _____ / _____ month day year	Total Number of Eligible Employees:	Total Number of Enrolled Employees:
New Employee Waiting Period *(check one)* ☐Flexible-*or*- ☐First day of the month following: ☐30 ☐60 ☐90 days -*or*- ☐_____days following date of hire -*or*- ☐ Date of Hire	Coverage for non-registered domestic partnerships? ☐Yes ☐No	Dual coverage allowed? ☐Yes ☐No

Participation

Employee Participation	Dependent Participation
_____%Employee Enrollment	_____%Dependent Enrollment
☐Tied to Medical	☐Tied to Medical

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 ☐Contract		Plan Type: ☐Local ☐National	
Benefit Coverage Levels	**Class I**	**Class II**	**Class III**
Percentage	_____%	_____%	_____%
Annual Maximum	$_____		
Diagnostic/Preventive Waiver (Class I Covered Dental Benefits do not accrue towards the Plan Maximum) Yes☐ 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: $_____ Children Only: Yes☐ No☐ Adult & Children: Yes☐ No☐			
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