DELTA DENTAL® Delta Dental of Washington

Enrollment Form

Large Group Dental and Vision Coverage

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

Type of Enrollment *(Check One)*

☐ **New** ☐ **Open Enrollment** ☐ **COBRA** ☐ **Reinstate** ☐ **Change** | ***Description of Changes:*** _____

☐ **Waive dental coverage (*select any that apply*):** ☐ Myself and all dependents ☐ Spouse/domestic partner* ☐ Dependent children**

If you are waiving dental coverage (this does not apply to vision), please review the "Waiver Dental Coverage" section before signing and submitting your form.

Subscriber Information *(please complete all fields)*

Employer or Group Name	Group Number	Subgroup	Hire Date	Effective Date	
First Name	Middle Initial	Last Name	Social Security Number	Birthdate	Gender
Address		City	State	ZIP Code	
Phone Number Is this a mobile number? ☐ Yes ☐ No		Email			
Dental Coverage: ☐ Add ☐ Remove		**Vision Coverage:** ☐ Add ☐ Remove			

Dependent Information

Please list all dependents to be covered (please attach a separate page if you are unable to list all dependents):

Name (First, Middle Initial, Last)	Relationship	Birthdate	Gender	Dental	Vision
	☐ Spouse or Domestic Partner* ☐ Dependent Child**			☐Add ☐Remove	☐Add ☐Remove
	Dependent Child**			☐Add ☐Remove	☐Add ☐Remove
	Dependent Child**			☐Add ☐Remove	☐Add ☐Remove
	Dependent Child**			☐Add ☐Remove	☐Add ☐Remove
	Dependent Child**			☐Add ☐Remove	☐Add ☐Remove

Are any of your dependents being covered past the limiting age due to incapacitation? ☐ Yes*** ☐ No

Coordination of Benefits

Please complete this section if you or your dependents have any other dental coverage:

Please check all that coverage applies to: ☐ Self ☐ Dependent(s) (Specify)_____			
Employer Group Number and Name	Effective Date		
Name and Address of Insurance Carrier			
Policy Holder Name (First, Middle Initial, Last)	Social Security Number	Birthdate	Gender

For additional COB information please attach a separate page or call (800) 554-1907.

COBRA Enrollment Only

Indicate Qualifying Date:
Indicate Qualifying Event: ☐ Termination ☐ Reduction in Hours ☐ Divorce ☐ Dissolution of Domestic Partnership ☐ Widowed/Surviving Dependent ☐ Dependent Child No longer Eligible ☐ Other

Dental Coverage Buy-Up (If Applicable)

Check One:

☐ I choose optional buy-up coverage for dental.
☐ I decline optional buy-up coverage for dental.

Contact your employer for more information.

Waiver Dental Coverage (If Applicable)

☐ I have been advised of the features and benefits of the dental plan offered to me through my employer. I understand that the benefits of the plan are only available to enrolled persons. After due consideration I have indicated my waiver selections on page one of this form.

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).

*Domestic partners include state-registered partnerships and/or other domestic partners if specifically covered by group.

**The minimum limiting age is through age 25 for all dependent children; coverage shall not terminate for children over the age of 25 who are both:
(1) incapable of self-sustaining employment by reason of developmental disability or physical handicap
(2) chiefly dependent upon the employee or member for support and maintenance

***Documentation is required to show that such child continues to be incapable of self-sustaining employment by reason of developmental or physical disability and that such child is chiefly dependent upon the employee or member for support and maintenance. For more information, please call us at 1-800-554-1907.

_____ _____
Signature Date