

**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.	

## Contribution / Participation

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

## Program Description

**DeltaCare® Plans for 100+ Employees**

Plan Name	TMJ Coverage	Ortho 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
<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
<input type="checkbox"/> 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 adults	<input type="checkbox"/> Child Only <input type="checkbox"/> Adult & Children
<input type="checkbox"/> National	<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"/> DeltaCare Ortho Plan A: \$1200 children/\$1600 adults <input type="checkbox"/> DeltaCare Ortho Plan B: \$1600 children/\$2000 adults	<input type="checkbox"/> Child Only <input type="checkbox"/> Adult & Children

**DeltaCare® Plans for Group with 51-99 Employees**

Plan Name	TMJ Coverage	Ortho Coverage	
<input type="checkbox"/> 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

## 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
- 1% Commission
- 3% Commission
- 5% Commission

	Plan Rates		Ortho Rates		TMJ Rates		Rates Sub-Total		Number of Employees		Premium
Employee		+		+		=		x		=	
Employee + Spouse*		+		+		=		x		=	
Employee + Child(ren)		+		+		=		x		=	
Employee + Family**		+		+		=		x		=	
							Total	=			

\*\* Employee and Family means an Employee and any dependents

\*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.

## 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