DELTA DENTAL® Delta Dental of Washington

# Enrollment Form

Large Group Dental 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:*** _____

## Subscriber Information *(please complete all fields)*

| Employer or Group Name | Group Number | Subgroup | Hire Date | Effective Date | |
|---|---|---|---|---|---|
| First Name | MI | Last Name | Social Security Number | Birthdate | Gender |
| Address | | City | State | ZIP Code | |
| Email | | Phone Number | | | |

## Dependent Information

Please list all dependents to be covered:

| First Name | Middle Initial | Last Name | Birthdate | Gender | Add / Remove | Does this person have other Dental Coverage? |
|---|---|---|---|---|---|---|
| Spouse or Domestic Partner* | | | | | Add ☐ Remove ☐ | ☐Yes ☐No |
| Dependent Child** | | | | | Add ☐ Remove ☐ | ☐Yes ☐No |
| Dependent Child** | | | | | Add ☐ Remove ☐ | ☐Yes ☐No |
| Dependent Child** | | | | | Add ☐ Remove ☐ | ☐Yes ☐No |
| Dependent Child** | | | | | Add ☐ Remove ☐ | ☐Yes ☐No |

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 ☐All Dependents with other coverage ☐Dependent(s) (Specify) _____

| Employer Group Number and Name | | | Effective Date | | |
|---|---|---|---|---|---|
| Name and Address of Insurance Carrier | | | | | |
| First Name | MI | Last Name | Social Security Number | Birthdate | Gender |

For additional COB information please submit on an additional form or call (800) 554-1907.

## COBRA Enrollment Only

| |
|---|
| Indicate Qualifying Date |
| Indicate Qualifying Event<br>☐Termination ☐Reduction in Hours ☐Divorce ☐Dissolution of Domestic Partnership ☐Widowed/Surviving Dependent<br>☐Dependent Child No longer Eligible ☐Other |

## Coverage Buy-Up (If Applicable)

**Check One**

☐ I choose optional buy-up coverage

☐ I decline optional buy-up coverage

Contact your employer for more information.

## Waiver Dental Coverage

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 chosen:

☐ Not to enroll my spouse or domestic partner in the group dental plan being offered by my employer.

☐ Not to enroll my children in the group dental plan being offered by my employer.

☐ Not to enroll myself and my dependents in the group dental plan being offered by my employer. I understand that by taking this action, I waive all benefits payable thereunder for myself and/or my dependents.

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