

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

Group Information

Group Name	Phone Number	Fax Number	
Address	City	State	ZIP Code
Representative Name	Title		
Tax ID Number (TIN)	NAICS Code (6 Digit)		
Email			

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

New Employee Waiting Period (<i>check one</i>): ☐ Flexible- <i>or</i> - ☐ First day of the month following: ☐ 30 ☐ 60 ☐ 90 days - <i>or</i> - ☐ _____ days following date of hire - <i>or</i> - ☐ Date of Hire	Total Number of Eligible Employees:	Total Number of Enrolled Employees:
	Domestic partner coverage? ☐ Any Domestic Partners - <i>or</i> - ☐ Registered Domestic Partners	Is dual coverage allowed? ☐ Yes ☐ No <i>This is when a member is covered under two plans by the same employer.</i>

Participation

Employee Participation (select one)	Dependent Participation (select one)
☐ _____ % Employee Enrollment ☐ Tied to Medical ☐ Voluntary	☐ _____ % Dependent Enrollment ☐ Tied to Medical ☐ Voluntary

Rates

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 year ☐ Contract Term		Plan Type: ☐ Local ☐ National	
Benefit Coverage Levels	Class I	Class II	Class III
Percentage	_____ %	_____ %	_____ %
Annual Maximum	\$ _____		
Diagnostic/Preventive Waiver: ☐ Yes (Class I covered dental benefits do not accrue towards the plan maximum) ☐ No			
Annual Deductible: ☐ Yes ☐ No Amount: Individual \$ _____ Family \$ _____			
Deductible Waived On: ☐ Class I ☐ Class II ☐ Class III ☐ Orthodontics ☐ Accidental Injury ☐ Other _____			
Orthodontic Lifetime Maximum: \$ _____ Coverage Type: ☐ Children Only ☐ Adult & Children			
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		Producer License Number	
Company Name		Phone Number	Fax Number
Address		City	State ZIP Code
Email			
Additional Producer Contact Information – Optional			
Account Manager Name	Phone Number	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