



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		
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

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	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		

## Dental Coverage Selections

### Participation

Employee Participation (select one)	Dependent Participation
<input type="checkbox"/> 75% enrollment of all Eligible Employees <input type="checkbox"/> 100% enrollment of all Eligible Employees	No Minimum

### Program Description

<b>Contract Effective Date:</b> _____		Contract period will be 12 continuous months from the effective date.	
The Benefit Period will be the Contract Effective Date through December 31st and January through December thereafter.			
DeltaCare® Plans for 51+ Employees			
Plan Name	TMJ Coverage	Ortho Coverage	Implant Coverage
<input type="checkbox"/> DeltaCare® Peak Plan	Surgical & Non-Surgical 50% to \$1,000 Annually with \$5,000 lifetime maximum	<input type="checkbox"/> No Coverage <input type="checkbox"/> Peak Ortho Plan A: \$1600 children/\$2000 adults	<input type="checkbox"/> No Coverage <input type="checkbox"/> Implant Coverage
<input type="checkbox"/> DeltaCare® Base Plan	Surgical & Non-Surgical 50% to \$1,000 Annually with \$5,000 lifetime maximum	<input type="checkbox"/> No Coverage <input type="checkbox"/> Base Ortho Plan A: \$1600 children/\$2000 adults	<input type="checkbox"/> No Coverage <input type="checkbox"/> Implant Coverage

## Vision Coverage Selections

If your group would like to enroll in a vision plan, please complete the selections below.

### Participation

Employee Participation (select one)	Dependent Participation (select one)
<input type="checkbox"/> 50% Employee Enrollment <input type="checkbox"/> Voluntary	<input type="checkbox"/> 50% Dependent Enrollment <input type="checkbox"/> Voluntary

### Plan Selection

VSP Plan Options – Administered by Vision Service Plan (VSP) – 3333 Quality Drive Rancho Cordova, CA 95670					
Plan Name	Copays	Exam	Frames	Lenses	LightCare™**
<input type="checkbox"/> DeltaVision® 150 LC	\$10 Exam \$25 Materials (Lenses/Frames)	1 x every 12 months	\$150 Plan Allowance 1 x every 24 months	1 x every 12 months	Included
<input type="checkbox"/> DeltaVision® 200 LC	\$10 Exam \$25 Materials (Lenses/Frames)	1 x every 12 months	\$200 Plan Allowance 1 x every 24 months	1 x every 12 months	Included
<input type="checkbox"/> DeltaVision® 150 Plus EasyOptions*	\$10 Exam \$10 Materials (Lenses/Frames)	1 x every 12 months	\$150 Plan Allowance (Plus 1 x every 12 months)	1 x every 12 months	Included
<input type="checkbox"/> DeltaVision® 200 Plus EasyOptions*	\$10 Exam \$10 Materials (Lenses/Frames)	1 x every 12 months	\$200 Plan Allowance 1 x every 12 months	1 x every 12 months	Included
<p>*EasyOptions is a customization feature that allows each member the option to choose one of the following upgrades at the time of service (when seen by a VSP Network Doctor): additional frame allowance, additional elective contact lens allowance, or a lens enhancement (progressive lenses, photochromic (light reactive) coating, or anti-glare coating).</p> <p>**LightCare is a customization feature that allows each member the option to use their frame and lens allowance for non-prescription sunglasses or non-prescription blue-light-filtering glasses, in place of prescription glasses (lenses and frames).</p>					

## Rates

The dental commission percentage chosen below will be incorporated into the dental Plan rates for groups of 51+ employees and will be included in the final Premium box located below.

Please note: This does not apply to vision.

0% Dental Plan Commission

3% Dental Plan Commission

5% Dental Plan Commission

	Dental Plan Rates		Vision Plan Rates		Ortho Rates		Implant Rates		Rates Sub-Total		Number of Employees		Premium
Employee		+		+		+		=		x		=	
Employee + Spouse****		+		+		+		=		x		=	
Employee + Child(ren)		+		+		+		=		x		=	
Employee + Family***		+		+		+		=		x		=	
***Employee and Family means an Employee and any dependents.									Total	=			

\*\*\*\*In Washington State, references to Married or Spouse apply equally to same-sex and opposite-sex spouse and to both registered and un-registered 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