

PO Box 75688  
Seattle WA 98175-0688  
(800) 554-1907

**New**    **Open Enrollment**    **COBRA**    **Reinstate**    **Change** | *Description of Changes:* \_\_\_\_\_

**Subscriber Information**

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		Email			

**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 <input type="checkbox"/> Remove <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child**					Add <input type="checkbox"/> Remove <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child**					Add <input type="checkbox"/> Remove <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child**					Add <input type="checkbox"/> Remove <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child**					Add <input type="checkbox"/> Remove <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

<b>Please check all that coverage applies to:</b>					
<input type="checkbox"/> Self <input type="checkbox"/> All Dependents with other coverage <input type="checkbox"/> Dependent(s) (Specify) _____					
Employer Group Number and Name				Effective Date	
Name and Address of Insurance Carrier					
First Name	Middle Initial	Last Name	Social Security Number	Birthdate	Gender

For additional COB information please submit on an additional form or call (800) 650-1583.

**COBRA Enrollment Only**

Indicate Qualifying Date
Indicate Qualifying Event <input type="checkbox"/> Termination <input type="checkbox"/> Reduction in Hours <input type="checkbox"/> Divorce <input type="checkbox"/> Dissolution of Domestic Partnership <input type="checkbox"/> Widowed/Surviving Dependent <input type="checkbox"/> Dependent Child No longer Eligible <input type="checkbox"/> Other

**DeltaCare Provider/Clinic Selection**

You must choose a dentist from the managed dental care provider list. This list can be accessed at [www.DeltaDentalWA.com/FindADentist](http://www.DeltaDentalWA.com/FindADentist) or by contacting us at 1-800-650-1583. All family members will be assigned to the same provider unless otherwise requested. Every attempt will be made to assign family members to the providers chosen. Confirmation of provider assignments will be mailed to you.

First Name	Middle Initial	Last Name	1st Provider Choice	Current Provider?	2nd Provider Choice	Current Provider?
Subscriber				Yes No <input type="checkbox"/> <input type="checkbox"/>		Yes No <input type="checkbox"/> <input type="checkbox"/>
Spouse or Domestic Partner*				Yes No <input type="checkbox"/> <input type="checkbox"/>		Yes No <input type="checkbox"/> <input type="checkbox"/>
Dependent				Yes No <input type="checkbox"/> <input type="checkbox"/>		Yes No <input type="checkbox"/> <input type="checkbox"/>
Dependent				Yes No <input type="checkbox"/> <input type="checkbox"/>		Yes No <input type="checkbox"/> <input type="checkbox"/>
Dependent				Yes No <input type="checkbox"/> <input type="checkbox"/>		Yes No <input type="checkbox"/> <input type="checkbox"/>
Dependent				Yes No <input type="checkbox"/> <input type="checkbox"/>		Yes No <input type="checkbox"/> <input type="checkbox"/>

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. To download the Disabled Dependent Application, visit the Delta Dental of Washington website at [www.DeltaDentalWA.com/forms](http://www.DeltaDentalWA.com/forms). You may also obtain a form by calling us at (800) 650-1583.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date