

Seattle
P.O Box 75688
Seattle, WA 98175-0688
(888) 286-9106

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: ____ / ____ / ____ month day year	Total Number of Eligible Employees:	Total Number of Enrolled Employees:
New Employee Waiting Period (<i>check one</i>) <input type="checkbox"/> Flexible- <i>or</i> - <input type="checkbox"/> First day of the month following: <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 days - <i>or</i> - <input type="checkbox"/> ____ days following date of hire - <i>or</i> - <input type="checkbox"/> Date of Hire	Coverage for non-registered domestic partnerships? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dual coverage allowed? <input type="checkbox"/> Yes <input type="checkbox"/> No

Participation

Employee Participation	Dependent Participation
____% Employee Enrollment	____% Dependent Enrollment
<input type="checkbox"/> Tied to Medical	<input type="checkbox"/> Tied to Medical

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	\$

*Spouse includes state registered domestic partners

Plan Description

Requested Effective Date: _____		Contract Term: _____ to _____	
Benefit Period: <input type="checkbox"/> Calendar <input type="checkbox"/> Contract		Plan Type: <input type="checkbox"/> Local <input type="checkbox"/> National	
Benefit Coverage	Class I	Class II	Class III
Percentage	_____ %	_____ %	_____ %
Annual Maximum	\$ _____		
Diagnostic/Preventive Waiver (class I Covered Dental Benefits do not accrue towards the Plan Maximum) Yes <input type="checkbox"/> No <input type="checkbox"/>			
Annual Deductible applies to: <input type="checkbox"/> In Network & Out of Network <input type="checkbox"/> Out of Network Only <input type="checkbox"/> In Network Only <input type="checkbox"/> No Deductible			
Amount - In Network: Individual \$ _____ Family \$ _____			
Amount - Out of Network: Individual \$ _____ Family \$ _____			
Deductible Waived On: <input type="checkbox"/> Class I <input type="checkbox"/> Class II <input type="checkbox"/> Class III <input type="checkbox"/> Orthodontics <input type="checkbox"/> Other _____			
Orthodontic Lifetime Maximum: \$ _____ Children Only: Yes <input type="checkbox"/> No <input type="checkbox"/> Adult & Children: Yes <input type="checkbox"/> No <input type="checkbox"/>			
Temporomandibular (TMJ) Coverage: Surgical – (paid at 50% to \$1,000 annual with \$5,000 lifetime maximum) Yes <input type="checkbox"/> No <input type="checkbox"/>			
Coordination of Benefits: <input type="checkbox"/> Standard (birthday rule) <input type="checkbox"/> Non-duplication of benefits (Self-Funded Groups Only)			
Dependent Children Covered to Age: _____ Student to Age: _____ (per RCW 48.44.215 the minimum is through age 25)			
Other Specific Benefits: _____			

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