DELTA DENTAL

Delta Dental of Washington

Application

Dental Coverage

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

Spokane
601 West Riverside Ave Suite 1720
Spokane, WA 99201-0626
(800) 564-8832

Group Information

Group # (Internal Use Only)

Group Name	Phone Number	Fax Number	
Address	City	State	ZIP Code
Representative Name	Title		
Email	Nature of Business		

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

Contract Effective Date _____ / _____ / _____ (month / day / year) The Contract Term is the 12-month period beginning on the Effective Date.	Total Number of Eligible Employees:	
	Total Number of Enrolled Employees:	

Benefit Period

- The Benefit Period for the Peak Incentive plan is the same as the Contract Term.
- The Benefit Period for all other plans is the Effective Date through December 31st, thereafter January through December.

Domestic Partners Covered (check one) ☐ All domestic partners ☐ State registered domestic partners only

Contribution / Participation (All Plans EXCEPT the Voluntary Plan, see below for Voluntary Plan information)

Employee Participation			Dependent Participation
Groups 5 — 9	Groups 10 — 50	Groups 51 — 99	
☐ 100% enrollment of all Eligible Employees	☐ 75% enrollment of Eligible Employees		☐ Minimum 50% enrollment of Eligible Dependents
☐ Tied to medical	☐ Tied to medical		☐ Tied to medical

Plan Selection (All Plans EXCEPT PPO Voluntary Plan)

Premier Plan						
Plan Name	In-Network Coverage	Out-of-Network Coverage	Annual Maximum	Annual Deductible	Orthodontics **(Minimum group size** 10)	Ortho Lifetime Max
☐ Delta Dental Premier®	☐ 100/90/60 | *n/a* ☐ 100/80/50 | *n/a*		☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500	☐ $0/$0 ☐ $25/$75 ☐ $50/$150	☐ Children ☐ Adults & Children	☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $3,000

PPO Plans						
Plan Name	In-Network Coverage	Out-of-Network Coverage	Annual Maximum	Annual Deductible	Orthodontics **(Minimum group size 10)**	Ortho Lifetime Max
☐ Delta Dental PPO℠	☐ 100/90/60 | 100/80/60 ☐ 100/90/50 | 100/80/50 ☐ 100/80/50 | 80/70/40		☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500	☐ $0/$0 ☐ $25/$75 ☐ $50/$150	☐ Children ☐ Adults & Children	☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $3,000
☐ Delta Dental PPO℠ – Peak Incentive	Class I 100-80% Class II 90%-70% Class III 50%		☐ $1,500 ☐ $2,000	In-Network $25/$75 Out-of-Network $50/$150	☐ Children ☐ Adults & Children	☐ $1,500 ☐ $2,000
☐ Delta Dental PPO℠ – Value ACH Form required	☐ 100/90/50 | 100/80/50 ☐ 100/80/50 | 80/70/40		☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500	☐ $0/$0 ☐ $25/$75 ☐ $50/$150	☐ Children ☐ Adults & Children	☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $3,000
☐ Delta Dental PPO℠ – Options	Core 100/50/0		$750	$50/$150	*No Ortho Coverage*	
	Plus 100/80/50		$1,500	$50/$150	Adults & Children	$1,500

SimpleChoice® Plan						
Plan Name	In-Network Coverage	Out-of-Network Coverage	Annual Maximum	Annual Deductible	Orthodontics **(Minimum group size 10)**	Ortho Lifetime Max
☐ SimpleChoice®	☐ 100/100/50 | *n/a* ☐ 100/80/50 | *n/a*		☐ $1,000 ☐ $1,500 ☐ $2,000	☐ $0/$0 ☐ $25/$75 ☐ $50/$150	Adults & Children Waiting Periods ☐ Yes ☐ No	☐ $1,000 ☐ $1,500 ☐ $2,000

Plan Selection (PPO Voluntary Plan Only)

PPO Voluntary Plans						
Plan Name	In-Network Coverage	Out-of-Network Coverage	Annual Maximum	Annual Deductible	Orthodontics **(Minimum group size 10)**	Ortho Lifetime Max
☐Delta Dental PPO SM – Voluntary Enhanced	☐ 100/90/50 ☐ 100/80/50		☐ $1,000 ☐ $1,500 ☐ $2,000	☐ $0/$0 ☐ $25/$75 ☐ $50/$150	☐ Children ☐ Adults & Children	☐ $1,000 ☐ $1,500
	☐ 100/80/50	☐ 80/70/40				
☐Delta Dental PPO SM – Voluntary Standard	☐ 100/80/50	☐ 80/70/40	☐ $1,000 ☐ $1,500 ☐ $2,000	☐ $0/$0 ☐ $25/$75 ☐ $50/$150	☐ Children ☐ Adults & Children	☐ $1,000 ☐ $1,500

Prior Coverage ☐ Yes ☐ No	Waiting period applies to Class III and Ortho without proof of prior dental coverage.	
Employer Contribution	Employee Participation	Dependent Participation
No Minimum	Five (5) Enrolled Employees or 20% of all Eligible Employees, whichever is greater	No Minimum

Rates

	Plan Rates		PPO Options Plus						Number of Employees		Premium**
Employee		+		+		=		x		=	
Employee + Spouse*		+		+		=		x		=	
Employee + Child(ren)		+		+		=		x		=	
Employee +Spouse+ Child(ren)		+		+		=		x		=	

*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.

**Binder check required with first month premium

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