DELTA DENTAL® Delta Dental of Washington

Enrollment Form

Small Group Dental Coverage

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 ☐ Remove ☐	☐ Yes ☐ No
Dependent Child**					Add ☐ Remove ☐	☐ Yes ☐ No
Dependent Child**					Add ☐ Remove ☐	☐ Yes ☐ No
Dependent Child**					Add ☐ Remove ☐	☐ Yes ☐ No
Dependent Child**					Add ☐ Remove ☐	☐ Yes ☐ 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.

Please check all that coverage applies to:
☐ Self ☐ All Dependents with other coverage ☐ 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) 554-1907.

COBRA Enrollment Only

Indicate Qualifying Date
Indicate Qualifying Event ☐ Termination ☐ Reduction in Hours ☐ Divorce ☐ Widowed/Surviving Dependent ☐ Dependent Child No longer Eligible ☐ Other

Waiver Dental Coverage

I certify that I have been advised of the features and benefits of the dental plan offered to me through my employer and after due consideration, I have chosen:

- ☐ Not to enroll my spouse in the group dental plan being offered by my employer.
- ☐ Not to enroll my children in the group dental plan being offered by my employer.
- ☐ Not to enroll myself and my dependents in the group dental plan being offered by my employer. I understand that by taking this action, I waive all benefits payable thereunder for myself and/or my dependents.

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 Incapacity and Dependency Form, visit the Delta Dental of Washington website at www.DeltaDentalWA.com/forms. You may also obtain a form by calling us at 1-888-899-3734.

_____ _____
Signature Date