



Washington Dental Service

Enrollment Form

Washington Dental Service is a member of the Delta Dental Plans Association

9706 4th Ave NE
Seattle, WA 98115-2157

New Change Open Enrollment Preshent® COBRA Reinstate Other

Employer or Group Name	Group Number	Sub Group	Hire Date	Effective Date	
Social Security Number	First Name	Middle Initial	Last Name	Birthdate	Gender
Address		City	State	Zip	
Phone Number		Email Address			

Please list all dependents to be covered.

First Name	Middle Initial	Last Name	Birthdate	Gender	Add/Remove	Dependent Over Limiting Age Verification*	Coordination of Benefits	
Spouse or Domestic Partner**				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dependent				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>	<input type="checkbox"/> FT Student <input type="checkbox"/> Incapacitated*** <input type="checkbox"/> Primarily Dependent	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dependent				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>	<input type="checkbox"/> FT Student <input type="checkbox"/> Incapacitated*** <input type="checkbox"/> Primarily Dependent	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dependent				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>	<input type="checkbox"/> FT Student <input type="checkbox"/> Incapacitated*** <input type="checkbox"/> Primarily Dependent	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dependent				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>	<input type="checkbox"/> FT Student <input type="checkbox"/> Incapacitated*** <input type="checkbox"/> Primarily Dependent	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Coordination of Benefits

Do any of your dependents have other dental coverage? Y N If yes, please complete the section below.

Employer Group Number and Name			Effective Date		
Name and Address of Other Insurance Carrier					
Social Security Number	First Name	Middle Initial	Last Name	Birthdate	Gender

COBRA Enrollment if Other Than Employee

COBRA Qualifying Event	Effective Date	Relationship to Above-named Subscriber <input type="checkbox"/> Spouse <input type="checkbox"/> Over Age Dependent <input type="checkbox"/> Other			
Social Security Number	First Name	Middle Initial	Last Name	Birthdate	Gender

Dependents of COBRA Enrollee

First Name	Initial	Last Name	Birthdate	Gender	Add/Remove	Dependent Over Limiting Age Verification*	Coordination of Benefits	
Dependent				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>	<input type="checkbox"/> FT Student <input type="checkbox"/> Incapacitated*** <input type="checkbox"/> Primarily Dependent	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dependent				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>	<input type="checkbox"/> FT Student <input type="checkbox"/> Incapacitated*** <input type="checkbox"/> Primarily Dependent	Yes <input type="checkbox"/>	No <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).

* For groups subject to RCW 48.44.215, the minimum limiting age is through 24.

** Domestic partners includes state registered partnerships and/or other domestic partners if specifically covered by group.

*** Documentation is required (pursuant to R.C.W. 48.44.210). To download the proof of incapacity and dependency form, visit the Washington Dental Service Web site at www.DeltaDentalWA.com/forms.

Signature _____ Date _____