

Delta Dental of Washington – Enrollment Form

NEW CHANGE OE

Effective Date:	Location <input type="checkbox"/> Govt #100 <input type="checkbox"/> Casino/Bingo #300 <input type="checkbox"/> TGA #400 <input type="checkbox"/> Quil Ceda Village #500 <input type="checkbox"/> Pharmacy #600				
EMPLOYEE INFORMATION:	TGOClock-In	Department			<input type="checkbox"/> Tulalip Native American <input type="checkbox"/> Native American Non-Tulalip
Social Security Number	First Name	Middle Initial	Last Name	Birthdate	Gender
Address		City	State	Zip	
Phone Number		Email Address			
DENTAL PLAN: (Choose one)	Copper Plan – Annual Maximum Limit \$1,500			Silver Plan – Annual Maximum Limit \$3,000	
	<input type="checkbox"/> Employee only = \$0 per month			<input type="checkbox"/> Employee only = \$16.00 per month	
	<input type="checkbox"/> Employee +1 = \$27.00 per month			<input type="checkbox"/> Employee +1 = \$59.00 per month	
	<input type="checkbox"/> Employee +2 or more = \$61.00 per month			<input type="checkbox"/> Employee + 2 or more = \$109.00 per month	

WAIVE DENTAL COVERAGE: I understand that the next opportunity to enroll in this plan is at the annual Open Enrollment Period.

PLEASE LIST ALL DEPENDENTS TO BE COVERED

First Name	Middle Initial	Last Name	Birthdate	Gender	Action	Dependent Over Limiting Age
Spouse or Domestic Partner				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/> Same <input type="checkbox"/>	***Verification Required
Dependent				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/> Same <input type="checkbox"/>	Incapacitated*** <input type="checkbox"/>
Dependent				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/> Same <input type="checkbox"/>	Incapacitated*** <input type="checkbox"/>
Dependent				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/> Same <input type="checkbox"/>	Incapacitated*** <input type="checkbox"/>
Dependent				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/> Same <input type="checkbox"/>	Incapacitated*** <input type="checkbox"/>

Coordination of Benefits Do any of your dependents have other dental coverage? Yes No If yes, please complete section below.

If Yes, please mark their names with an asterisk in the table (*) above.

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

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).

* The minimum limiting age is through age 25 for all 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 and (2) chiefly dependent upon the employee or member for support and maintenance

** Domestic partners include 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 Delta Dental of Washington website at www.DeltaDentalWA.com/forms.

Signature _____ Date _____

