DELTA DENTAL®

Delta Dental of Washington

PO Box 75688 | Seattle WA 98175-0688
(206) 528-5335 or (800) 572-7835 x 5335

Enrollment Form

DDWA Small Business Plans

☐ New ☐ Change ☐ Open Enrollment ☐ COBRA ☐ Reinstate ☐ Other (Check One)

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

Dependents

Please list all dependents to be covered:

First Name	Middle Initial	Last Name	Birthdate	Gender	Add/ Remove	Dependent Over Limiting Age Verification*
Spouse or Domestic Partner**				M ☐ F ☐	Add ☐ Remove ☐	
Dependent				M ☐ F ☐	Add ☐ Remove ☐	Incapacitated*** ☐
Dependent				M ☐ F ☐	Add ☐ Remove ☐	Incapacitated*** ☐
Dependent				M ☐ F ☐	Add ☐ Remove ☐	Incapacitated*** ☐
Dependent				M ☐ F ☐	Add ☐ Remove ☐	Incapacitated*** ☐

Coordination of Benefits

Do any of your dependents have other dental coverage? Yes ☐ No ☐ 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 Only

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

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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).

* 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 _____