DELTA DENTAL®
Washington Dental Service
Washington Dental Service is a member of the Delta Dental Plans Association

Enrollment Form

☐ New ☐ Change ☐ Open Enrollment ☐ Preshent™ ☐ COBRA ☐Other

1. Subscriber and Dependent Information

Employer or Group Name	Group Number	Sub Group	Hire Date	Effective Date

Last Name	First Name	Middle

Social Security Number	Birthdate	Phone Number

Address	City	State	Zip

Please list all dependents to be covered.

Spouse

Last Name	First Name	Gender M☐ F☐	Add ☐ Remove ☐	Birthdate		WDS Use Only Deductible	WDS Use Only Incentive

Dependents

Last Name	First Name	Gender M☐ F☐	Add ☐ Remove ☐	Birthdate	Check below if dependent is over-age, a full-time student or incapacitated. ☐ FT Student ☐ Incapacitated ☐ Primarily Dependent	WDS Use Only Deductible	WDS Use Only Incentive

Failure to provide accurate, complete and truthful information can result in denial of benefits as well as possible civil and criminal penalties. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. I hereby request dental plan coverage offered through my employer. I authorize my employer to deduct the dental plan premium from my earnings, including any future adjustments and required contributions. I reserve the right to revoke or change this authorization by written notice and understand that if I have declined any coverage for myself or eligible dependent and wish to enroll at a later date, coverage will be deferred in accordance with the plan provisions. I understand and acknowledge that information concerning coverages, treatments and services I may receive may be distributed and disclosed to my employer; I hereby consent to the dissemination and disclosure of all information. I declare all answers true and complete to the best of my knowledge.

Signature Date

2. Coverage Buy-Up

☐ I choose optional buy-up coverage. ☐ I decline optional buy-up coverage.

3. COBRA Event Date

COBRA state qualifying event	Effective Date

4. Other Dental Insurance Coverage

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	Last Name	First Name	Middle	Birthdate

5. 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.

Signature Date