

400 Fairview Ave N Suite 800
Seattle, WA 98109-5371
(877) 404-0364

Group Information

Group Name		Phone Number	Fax Number	
Address		City	State	ZIP Code
Representative Name		Title		
Email	NAICS Code	Nature of Business		

Billing Information (please complete if different than Group Information)

Company Name		Phone Number	Fax Number	
Billing Address		City	State	ZIP Code
Billing Representative Name		Title		
Email				

Participation

Employee Participation		
All Plans except Voluntary Plans (Select One)		Voluntary Plans
Groups 2 — 9	Groups 10 — 50	Groups 2-50
<input type="checkbox"/> 100% Employee Enrollment <input type="checkbox"/> Tied to Medical	<input type="checkbox"/> 75% Employee Enrollment <input type="checkbox"/> Tied to Medical	Two (2) Enrolled Employees or 20% of all Eligible Employees, whichever is greater
Total Number of Eligible Employees: _____		Total Number of Enrolled Employees: _____
Dependent Participation		
All Plans except Voluntary Plans (Select One)		Voluntary Plans
<input type="checkbox"/> Minimum 50% Dependent Enrollment <input type="checkbox"/> Tied to Medical		No Minimum
Domestic Partners Covered (check one) <input type="checkbox"/> All domestic partners <input type="checkbox"/> State registered domestic partners only		

Dental Plan Selection

Contract Effective Date: _____		Contract Term will be 12 continuous months from the effective date.				
The Benefit Period will be the Contract Effective Date and ending the last day of the calendar year; thereafter January through December.						
DeltaCare Plans						
Plan Name	TMJ Coverage	Orthodontic Coverage		Implant Coverage		
<input type="checkbox"/> DeltaCare® Peak Plan	Surgical & Non-Surgical 50% to \$1,000 Annually with \$5,000 lifetime maximum	<input type="checkbox"/> No Coverage <input type="checkbox"/> \$1,600 children/\$2,000 adults		<input type="checkbox"/> No Coverage <input type="checkbox"/> Implant Coverage		
<input type="checkbox"/> DeltaCare® Base Plan	Surgical & Non-Surgical 50% to \$1,000 Annually with \$5,000 lifetime maximum	<input type="checkbox"/> No Coverage <input type="checkbox"/> \$1,600 children/\$2,000 adults		<input type="checkbox"/> No Coverage <input type="checkbox"/> Implant Coverage		
PPO Plans						
Plan Name	In-Network Coverage	Out-of-Network Coverage	Annual Maximum	Annual Deductible	Orthodontics (Minimum group size 10)	Ortho Lifetime Max
<input type="checkbox"/> Delta Dental PPO SM	<input type="checkbox"/> 100/90/60 100/80/60 <input type="checkbox"/> 100/90/50 100/80/50 <input type="checkbox"/> 100/80/50 80/70/40		<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$4,000	<input type="checkbox"/> \$0/\$0 <input type="checkbox"/> \$25/\$75 <input type="checkbox"/> \$50/\$150	<input type="checkbox"/> Children <input type="checkbox"/> Adults & Children <input type="checkbox"/> No Ortho	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000
<input type="checkbox"/> Delta Dental PPO SM – Core/Buy-up	<input type="checkbox"/> Core 80/50/0		\$750	\$50/\$150	No Ortho Coverage	
	Buy-up 100/80/50		\$2,000	\$50/\$150	<input type="checkbox"/> Adults & Children <input type="checkbox"/> No Ortho	\$1,500
	<input type="checkbox"/> Core 100/50/0		\$750	\$50/\$150	No Ortho Coverage	
	Buy-up 100/80/50		\$1,500	\$50/\$150	<input type="checkbox"/> Adults & Children <input type="checkbox"/> No Ortho	\$1,500
	<input type="checkbox"/> Core 100/80/50		\$1,000	\$50/\$150	No Ortho Coverage	
	Buy-up 100/90/60		\$2,000	\$50/\$150	<input type="checkbox"/> Adults & Children <input type="checkbox"/> No Ortho	\$1,500
<input type="checkbox"/> Delta Dental PPO SM – Maximum Wellness	<input type="checkbox"/> 100/80/50 100/80/50		\$1,000 to \$1,500 (\$100 increments)	\$50/\$150	<input type="checkbox"/> Adults & Children <input type="checkbox"/> No Ortho	\$1,000
	<input type="checkbox"/> 100/80/50 100/80/50		\$2,000 to \$2,500 (\$100 increments)	\$50/\$150	<input type="checkbox"/> Adults & Children <input type="checkbox"/> No Ortho	\$1,500
PPO Voluntary Plans						
Plan Name	In-Network Coverage	Out-of-Network Coverage	Annual Maximum	Annual Deductible	Orthodontics (Minimum group size 10)	Ortho Lifetime Max
<input type="checkbox"/> Delta Dental PPO SM – Voluntary Enhanced	<input type="checkbox"/> 100/90/50 100/80/50		<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$0/\$0	<input type="checkbox"/> Children	<input type="checkbox"/> \$1,000
	<input type="checkbox"/> 100/80/50 80/70/40		<input type="checkbox"/> \$1,500	<input type="checkbox"/> \$25/\$75	<input type="checkbox"/> Adults & Children	<input type="checkbox"/> \$1,500
			<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$50/\$150	<input type="checkbox"/> No Ortho	<input type="checkbox"/> \$3,000
<input type="checkbox"/> Delta Dental PPO SM – Voluntary Standard	<input type="checkbox"/> 100/80/50 80/70/40		<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$0/\$0	<input type="checkbox"/> Children	<input type="checkbox"/> \$1,000
			<input type="checkbox"/> \$1,500	<input type="checkbox"/> \$25/\$75	<input type="checkbox"/> Adults & Children	<input type="checkbox"/> \$1,500
			<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$50/\$150	<input type="checkbox"/> No Ortho	

Optional Vision Plan Selection (only available in addition to the selection of a dental plan)

VSP Plan Options – Administered by Vision Service Plan (VSP) – 3333 Quality Drive Rancho Cordova, CA 95670				
Plan Name	Copays	Exam	Frames	Lenses
<input type="checkbox"/> DeltaVision® – 150	\$10 Exam \$25 Materials (Lenses/Frames)	1 x every 12 months	\$150 Plan Allowance 1 x every 24 months	1 x every 12 months
<input type="checkbox"/> DeltaVision® – 150 Plus	\$10 Exam \$10 Materials (Lenses/Frames)	1 x every 12 months	\$150 Plan Allowance 1x every 12 months	1 x every 12 months

Rates

	Dental		Optional Vision Rates
	Plan Rates	PPO Buy-up Rates	
Employee	\$	\$	\$
Employee + Spouse***	\$	\$	\$
Employee + Child(ren)	\$	\$	\$
Employee + Spouse + Child(ren)	\$	\$	\$

***In Washington State, references to Spouse apply equally to same-sex and opposite-sex spouse and to both registered and unregistered domestic partnerships

Insurance Producer Information

Producer Name	License Number		
Company Name	Phone Number	Fax Number	
Address	City	State	ZIP Code
Email			

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. Delta Dental of Washington reserves the right to audit any information provided herein for compliance and accuracy.

_____ Company Representative/Title (Please Print)	_____ Signature	_____ Date
_____ Insurance Producer/Title (Please Print)	_____ Signature	_____ Date