DELTA DENTAL® Delta Dental of Washington

Application

Large Group Dental and Vision Coverage
Delta Dental PPO

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 (3-4 Digit)		

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			

Employee Eligibility

New Employee Waiting Period *(check one):*	Total Number of Eligible Employees:	Total Number of Enrolled Employees:
☐ Flexible *-or-* ☐ First day of the month following: ☐ 30 ☐ 60 ☐ 90 days *-or-* ☐_____days following date of hire *-or-* ☐ Date of Hire	Coverage for non-registered domestic partnerships? ☐ Yes ☐ No	Dual coverage allowed? ☐ Yes ☐ No

Dental Coverage Selections

Participation

Employee Participation (select one)	Dependent Participation (select one)
☐ _____% Employee Enrollment ☐ Tied to Medical ☐ Voluntary	☐ _____% Dependent Enrollment ☐ Tied to Medical ☐ Voluntary

Plan Description

Requested Effective Date: _____		**Contract Term:** _____ to _____	
Benefit Period: ☐ Calendar year ☐ Contract Term		**Plan Type:** ☐ Local ☐ National	
Benefit Coverage Levels	**In-Network Delta Dental PPO Dentist**	**Out-of-Network Non-PPO Dentist**	**Out-of-State Dentist (Local Plans Only)**
Class I	_____%	_____%	_____%
Class II	_____%	_____%	_____%
Class III	_____%	_____%	_____%
Orthodontic Benefits	_____%	_____%	_____%
Annual Maximum	$_____	$_____	$_____

Diagnostic/Preventive Waiver: ☐ Yes (Class I covered dental benefits do not accrue towards the plan maximum) ☐ No

Annual Deductible applies to: ☐ In-Network & Out-of-Network ☐ Out-of-Network Only ☐ In-Network Only ☐ No Deductible

Amount – In-Network: Individual $ _____ Family $ _____

Amount – Out-of-Network: Individual $ _____ Family $ _____

Deductible Waived On: ☐ Class I ☐ Class II ☐ Class III ☐ Orthodontics ☐ Accidental Injury ☐ Other_____

Orthodontic Lifetime Maximum: $_____ Coverage Type: ☐ Children Only ☐ Adult & Children

Temporomandibular (TMJ) Coverage Surgical (paid at 50% to $1,000 annual with $5,000 lifetime maximum): ☐ Yes ☐ No

Coordination of Benefits: ☐ Standard (birthday rule) ☐ Non-duplication of benefits (Self-Funded Groups Only)

Dependent Children Covered to Age:_____(per RCW 48.44.215 the minimum is through age 25)

Other Specific Benefits:_____

Vision Coverage Selections

If your group would like to enroll in a vision plan, please complete the selections below.

Participation

Employee Participation (select one)	Dependent Participation (select one)
☐ 50% Employee Enrollment ☐ Voluntary	☐ 50% Dependent Enrollment ☐ Voluntary

Plan Selection

VSP Plan Options – Administered by Vision Service Plan (VSP) – *3333 Quality Drive Rancho Cordova, CA 95670*					
Plan Name	**Copays**	**Exam**	**Frames**	**Lenses**	**LightCare™****
☐ DeltaVision® 150 LC	$10 Exam $25 Materials (Lenses/Frames)	1 x every 12 months	$150 Plan Allowance 1 x every 24 months	1 x every 12 months	Included
☐ DeltaVision® 200 LC	$10 Exam $25 Materials (Lenses/Frames)	1 x every 12 months	$200 Plan Allowance 1 x every 24 months	1 x every 12 months	Included
☐ DeltaVision® 150 Plus EasyOptions*	$10 Exam $10 Materials (Lenses/Frames)	1 x every 12 months	$150 Plan Allowance (Plus 1 x every 12 months	1 x every 12 months	Included
☐ DeltaVision® 200 Plus EasyOptions*	$10 Exam $10 Materials (Lenses/Frames)	1 x every 12 months	$200 Plan Allowance 1 x every 12 months	1 x every 12 months	Included

*EasyOptions is a customization feature that allows each member the option to choose one of the following upgrades at the time of service (when seen by a VSP Network Doctor): additional frame allowance, additional elective contact lens allowance, or a lens enhancement (progressive lenses, photochromic (light reactive) coating, or anti-glare coating).

**LightCare is a customization feature that allows each member the option to use their frame and lens allowance for non-prescription sunglasses or non-prescription blue-light-filtering glasses, in place of prescription glasses (lenses and frames).

Rates

Rate Tiers	Dental Rates	Vision Rates
Employee Only	$	$
Employee + Spouse***	$	$
Employee + Child(ren)	$	$
Employee + Spouse*** + two (2) or more Children	$	$
Other Rate Tiers (if applicable)		
Employee + 1	$	$
Employee + 2	$	$
Composite	$	$
ASC Fee	$	$

***In Washington State, references to Married or 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