

400 Fairview Ave N Suite 800  
 Seattle WA 98109-5371  
 (800) 554-1907

Type of Enrollment (*Check One*)

New  Open Enrollment  COBRA  Reinstatement  Change | *Description of Changes:* \_\_\_\_\_

**Subscriber Information** (*please complete all fields*)

Employer or Group Name	Group Number	Subgroup	Hire Date	Effective Date	
First Name	Middle Initial	Last Name	Social Security Number	Birthdate	Gender
Address		City	State	ZIP Code	
Phone Number		Email			
Is this a mobile number? <input type="checkbox"/> Yes <input type="checkbox"/> No					

**Dependent Information**

Please list all dependents to be covered (please attach a separate page if you are unable to list all dependents):

Name (First, Middle Initial, Last)	Relationship	Birthdate	Gender	Add/Remove	
	<input type="checkbox"/> Spouse or Domestic Partner* <input type="checkbox"/> Dependent Child**			Add <input type="checkbox"/>	Remove <input type="checkbox"/>
	Dependent Child**			Add <input type="checkbox"/>	Remove <input type="checkbox"/>
	Dependent Child**			Add <input type="checkbox"/>	Remove <input type="checkbox"/>
	Dependent Child**			Add <input type="checkbox"/>	Remove <input type="checkbox"/>
	Dependent Child**			Add <input type="checkbox"/>	Remove <input type="checkbox"/>

Are any of your dependents being covered past the limiting age due to incapacitation?  Yes\*\*\*  No

**Coordination of Benefits**

Please complete this section if you or your dependents have any other dental coverage:

<b>Please check all that coverage applies to:</b> <input type="checkbox"/> Self <input type="checkbox"/> Dependent(s) (Specify) _____			
Employer Group Number and Name		Effective Date	
Name and Address of Insurance Carrier			
Policy Holder Name (First, Middle Initial, Last)	Social Security Number	Birthdate	Gender

For additional COB information please attach a separate page or call (800) 650-1583.

**COBRA Enrollment Only**

Indicate Qualifying Date:
Indicate Qualifying Event: <input type="checkbox"/> Termination <input type="checkbox"/> Reduction in Hours <input type="checkbox"/> Divorce <input type="checkbox"/> Dissolution of Domestic Partnership <input type="checkbox"/> Widowed/Surviving Dependent <input type="checkbox"/> Dependent Child No longer Eligible <input type="checkbox"/> Other

**DeltaCare Provider/Clinic Selection**

You must select a Primary Care Dentist (PCD) that participates in the DeltaCare Network. You can search for a DeltaCare Network Dentist at [www.DeltaDentalWA.com](http://www.DeltaDentalWA.com) or by contacting us at (800) 650-1583. All family members will be assigned to the same provider unless otherwise requested. Every attempt will be made to assign family members to the providers chosen. Confirmation of provider assignments will be mailed to you. Treatment received from a provider who is not your assigned PCD is not a benefit under this plan.

Name (First, Middle Initial, Last)	1st Provider Choice	Current Provider?	2nd Provider Choice	Current Provider?
Subscriber		Yes No <input type="checkbox"/> <input type="checkbox"/>		Yes No <input type="checkbox"/> <input type="checkbox"/>
Spouse or Domestic Partner*		Yes No <input type="checkbox"/> <input type="checkbox"/>		Yes No <input type="checkbox"/> <input type="checkbox"/>
Dependent Child**		Yes No <input type="checkbox"/> <input type="checkbox"/>		Yes No <input type="checkbox"/> <input type="checkbox"/>
Dependent Child**		Yes No <input type="checkbox"/> <input type="checkbox"/>		Yes No <input type="checkbox"/> <input type="checkbox"/>
Dependent Child**		Yes No <input type="checkbox"/> <input type="checkbox"/>		Yes No <input type="checkbox"/> <input type="checkbox"/>
Dependent Child**		Yes No <input type="checkbox"/> <input type="checkbox"/>		Yes No <input type="checkbox"/> <input type="checkbox"/>

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).

\*Domestic partners include state-registered partnerships and/or other domestic partners if specifically covered by group.

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

\*\*\*Documentation is required to show that such child continues to be incapable of self-sustaining employment by reason of developmental or physical disability and that such child is chiefly dependent upon the employee or member for support and maintenance. You may obtain a form by calling us at (800) 650-1583.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date