DELTA DENTAL

Delta Dental of Washington

Group Application

SG 51-99 Dental and Vision Coverage

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			

Eligibility

Total Number of Eligible Employee: ___________________	**Domestic Partners Covered** (check one)
	☐ All domestic partners
Total Number of Enrolled Employees: _________________	☐ State registered domestic partners only

Dental Coverage Selections

Participation

Employee Participation	
All Plans except Voluntary Plans (Select One)	**Voluntary Plans**
☐ 75% Employee Enrollment ☐ Tied to Medical	Two (2) Enrolled Employees or 20% of all Eligible Employees, whichever is greater
Dependent Participation	
All Plans except Voluntary Plans (Select One)	**Voluntary Plans**
☐ Minimum 50% Dependent Enrollment ☐ Tied to Medical	No Minimum

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
☐ DeltaCare® Peak Plan	Surgical & Non-Surgical 50% to $1,000 Annually with $5,000 lifetime maximum	☐ No Coverage ☐ $1,600 children/$2,000 adults	☐ No Coverage ☐ Implant Coverage
☐ DeltaCare® Base Plan	Surgical & Non-Surgical 50% to $1,000 Annually with $5,000 lifetime maximum	☐ No Coverage ☐ $1,600 children/$2,000 adults	☐ No Coverage ☐ 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
☐ Delta Dental PPO℠	☐ 100/90/60 ☐ 100/90/50 ☐ 100/80/50	100/80/60 100/80/50 80/70/40	☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500 ☐ $4,000	☐ $0/$0 ☐ $25/$75 ☐ $50/$150	☐ Children ☐ Adults & Children ☐ No Ortho	☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $3,000
☐ Delta Dental PPO℠ – Core/Buy-up	☐ Core 80/50/0		$750	$50/$150	No Ortho Coverage	
	Buy-up 100/80/50		$2,000	$50/$150	☐ Adults & Children ☐ No Ortho	$1,500
	☐ Core 100/50/0		$750	$50/$150	No Ortho Coverage	
	Buy-up 100/80/50		$1,500	$50/$150	☐ Adults & Children ☐ No Ortho	$1,500
	☐ Core 100/80/50		$1,000	$50/$150	No Ortho Coverage	
	Buy-up 100/90/60		$2,000	$50/$150	☐ Adults & Children ☐ No Ortho	$1,500
☐ Delta Dental PPO℠ – Maximum Wellness	☐ 100/80/50	100/80/50	$1,000 to $1,500 ($100 increments)	$50/$150	☐ Adults & Children ☐ No Ortho	$1,000
	☐ 100/80/50	100/80/50	$2,000 to $2,500 ($100 increments)	$50/$150	☐ Adults & Children ☐ 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
☐ Delta Dental PPO℠ – Voluntary Enhanced	☐ 100/90/50 ☐ 100/80/50	100/80/50 80/70/40	☐ $1,000 ☐ $1,500 ☐ $2,000	☐ $0/$0 ☐ $25/$75 ☐ $50/$150	☐ Children ☐ Adults & Children ☐ No Ortho	☐ $1,000 ☐ $1,500 ☐ $3,000
☐ Delta Dental PPO℠ – Voluntary Standard	☐ 100/80/50	80/70/40	☐ $1,000 ☐ $1,500 ☐ $2,000	☐ $0/$0 ☐ $25/$75 ☐ $50/$150	☐ Children ☐ Adults & Children ☐ No Ortho	☐ $1,000 ☐ $1,500

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 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

	Dental		**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