DELTA DENTAL®

Delta Dental of Washington

Application for Small Group Dental Coverage

P.O. Box 75983 | Seattle WA 98175-0983
(206) 528-5335 or (800) 572-7835 x 5335

Group Information

New Group # (Internal Use Only)

Group Name	Phone Number	Fax Number	
Street Address	City	State	Zip Code
Billing Address (if different from street address)	City	State	Zip Code
Company Representative (name)	Title		
Company Representative E-mail Address			
Billing Contact Name (if different)	Title		
Billing Contact E-mail Address			
Type/Nature of Business			

Employee Eligibility

Effective Date (Contract period will be 12 continuous months from the effective date, the Benefit Period will be the effective date through December 31st and January through December thereafter.)	Number of Total Employees	Number of Enrolled Employees
_____ / _____ / _____ mo day year	_____	_____

Coverage for non-state registered domestic partnerships	New Employee Waiting Period (check one)
☐ Yes ☐ No	First of the month following: ☐ 30 ☐ 60 ☐ 90 days _____ months after date of hire (A minimum of 80 hours per month constitutes full-time employment.)

Contribution / Participation

Employer Contribution	Employee Participation		Dependent Participation
	Groups 5 — 9	Groups 10 — 99	
_____% Employer Contribution (Must be a minimum of 50% or more employer-paid.)	☐ 100% enrollment of all eligible employees ☐ Tied to medical	☐ 75% enrollment of eligible employees ☐ Tied to medical	_____% (Minimum 50% or more enrollment of eligible dependents) ☐ Tied to medical

Voluntary PPO Plan Only

Employer Contribution	Employee Participation	Dependent Participation
☐ No Minimum	☐ Five (5) enrolled employees or 20% of all eligible employees, whichever is greater	☐ No Minimum

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Plan Section

Premier Plans

		Annual Maximum	Annual Deductible	Orthodontics (Minimum group size 10)	Optional Coverage
Delta Dental Premier Plans®	☐ 100/90/60 ☐ 100/90/50 ☐ 100/80/50 ☐ 80/80/50	☐ $750 ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500 ☐ $3,000	☐ $0/$0 ☐ $25/$75 ☐ $50/$150 ☐ $75/$225 ☐ $100/$300	☐ Children Only ☐ Adults & Children Lifetime Maximum ☐ $1,000 ☐ $1,500 ☐ $2,000	Posterior Composite Coverage ☐ Yes ☐ No

PPO Plans

		Annual Maximum	Annual Deductible	Orthodontics (Minimum group size 10)	Optional Coverage
Delta Dental PPO Plans	☐ 100/90/60 – 100/80/60 ☐ 100/90/50 – 100/80/50 ☐ 100/80/50 – 80/70/40 ☐ 80/80/50 – 70/70/40	☐ $750 ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500 ☐ $3,000	☐ $0/$0 ☐ $25/$75 ☐ $50/$150 ☐ $75/$225 ☐ $100/$300	☐ Children Only ☐ Adults & Children Lifetime Maximum ☐ $1,000 ☐ $1,500 ☐ $2,000	Posterior Composite Coverage ☐ Yes ☐ No
Delta Dental PPO Voluntary Plans	☐ 100/80/50 – 80/70/40 Enhanced (With periodontics and endodontics in Class II) ☐ 100/80/50 – 80/70/40 Standard (With periodontics and endodontics in Class III) ☐ 80/80/50 – 70/70/40 Enhanced (With periodontics and endodontics in Class II) ☐ 80/80/50 – 70/70/40 Standard (With periodontics and endodontics in Class III)	☐ $1,000 ☐ $1,500	☐ $50/$150 ☐ $75/$225	☐ Children Only Lifetime Maximum ☐ $1,000 ☐ $1,500	Posterior Composite Coverage ☐ Yes ☐ No
☐ Delta Dental PPO Value Plan ☐ Delta Dental PPO Basic Plan	☐ 100/90/60 – 100/80/60 ☐ 100/90/50 – 100/80/50 ☐ 100/80/50 – 80/70/40 ☐ 80/80/50 – 70/70/40	☐ $750 ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500 ☐ $3,000	☐ $0/$0 ☐ $25/$75 ☐ $50/$150 ☐ $75/$225 ☐ $100/$300	☐ Children Only ☐ Adults & Children Lifetime Maximum ☐ $1,000 ☐ $1,500 ☐ $2,000	Posterior Composite Coverage ☐ Yes ☐ No

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SimpleChoice Plan

		Annual Maximum	Annual Deductible	Orthodontics (Minimum group size 10)		Optional Coverage
SimpleChoice™	☐ 100/100/50 ☐ 100/80/50 ☐ 80/80/50	☐ $1,000 ☐ $1,500 ☐ $2,000	☐ $0/$0 ☐ $25/$75 ☐ $50/$150 ☐ $75/$225	☐ Adults & Children	Lifetime Maximum ☐ $1,000 ☐ $1,500 ☐ $2,000	Waiting Periods ☐ Yes ☐ No

Rates

	Plan Rates		Ortho Rates from Rider		Optional Rider Rates		Rates Sub-Total		Number of Employees		Premium
Employee		+		+		=		x		=	
Employee + Spouse*		+		+		=		x		=	
Employee + Child(ren)*		+		+		=		x		=	
Employee + Family*		+		+		=		x		=	
					First Month's Premium		Total	=			

*Spouse includes state registered domestic partners.

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Insurance Producer Information

Insurance Producer	Phone Number		
Insurance Producer Company Name	Fax Number		
Insurance Producer Address	City	State	Zip Code
E-mail Address			

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)	Authorized Signature	Date
Insurance Producer/Title (Please Print)	Authorized Signature	Date

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