DELTA DENTAL®
Washington Dental Service
Washington Dental Service is a member of the Delta Dental Plans Association

9706 4th Ave NE Seattle, WA 98115-2157

DeltaCare®
Enrollment Form

☐ New ☐ Change ☐ Open Enrollment ☐ COBRA ☐ Reinstate ☐ Other (Check One)

Employer or Group Name	Group Number	Subgroup	Hire Date	Effective Date	
Social Security Number	First Name	Middle Initial	Last Name	Birthdate	Gender
Address		City	State	Zip	
Phone Number		Email Address			

Dependents

Please list all dependents to be covered:

First Name	Middle Initial	Last Name	Birthdate	Gender	Add/ Remove	Dependent Over Limiting Age Verification*	Coordination of Benefits
Spouse or Domestic Partner**				M ☐ F ☐	Add ☐ Remove ☐		Yes ☐ No ☐
Dependent				M ☐ F ☐	Add ☐ Remove ☐	☐ FT Student ☐ Incapacitated*** ☐ Primarily Dependent	Yes ☐ No ☐
Dependent				M ☐ F ☐	Add ☐ Remove ☐	☐ FT Student ☐ Incapacitated*** ☐ Primarily Dependent	Yes ☐ No ☐
Dependent				M ☐ F ☐	Add ☐ Remove ☐	☐ FT Student ☐ Incapacitated*** ☐ Primarily Dependent	Yes ☐ No ☐
Dependent				M ☐ F ☐	Add ☐ Remove ☐	☐ FT Student ☐ Incapacitated*** ☐ Primarily Dependent	Yes ☐ No ☐

Coordination of Benefits

Do any of your dependents have other dental coverage? Yes ☐ No ☐ If yes, please complete the section below.

Employer Group Number and Name			Effective Date		
Name and Address of Other Insurance Carrier					
Social Security Number	First Name	Middle Initial	Last Name	Birthdate	Gender

COBRA Enrollment Only

Indicate Qualifying Date
Indicate Qualifying Event ☐ Termination ☐ Reduction in Hours ☐ Divorce ☐ Widowed/Surviving Dependent ☐ Dependent Child No Longer Eligible ☐ Other

 Continued on back ⇨

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DeltaCare Provider/Clinic Selection

You must choose a dentist from the managed dental care provider list at **www.DeltaDentalWA.com/FindADentist**. 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.

First Name	Middle Initial	Last Name	1st Provider Choice	2nd Provider Choice	Current Provider?
Subscriber					Yes ☐ No ☐
Spouse or Domestic Partner**					Yes ☐ No ☐
Dependent					Yes ☐ No ☐
Dependent					Yes ☐ No ☐
Dependent					Yes ☐ No ☐
Dependent					Yes ☐ No ☐

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).

*The minimum limiting age is as defined by state and federal regulations.

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

***Documentation is required (pursuant to R.C.W. 48.44.210). To download the proof of incapacity and dependency form, visit the Washington Dental Service Web site at **www.DeltaDentalWA.com/forms.**

Signature _______________________________ Date __________