

New Hire Change Open Enrollment COBRA Reinstatement Other (Check One)

Employer complete this section:

Group Number _____ Subgroup _____
 Please indicate current dental rate \$ _____ and your WEA Dental Plan # _____ and Ortho if applicable _____

School District			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**
Spouse or Domestic Partner*				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>	
Dependent				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>	Incapacitated <input type="checkbox"/>
Dependent				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>	Incapacitated <input type="checkbox"/>
Dependent				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>	Incapacitated <input type="checkbox"/>
Dependent				M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>	Incapacitated <input type="checkbox"/>

Incentive Level Transfer Information

WEA Select Dental Plan? Yes No
 WDS: _____; Willamette: _____; # of Years: _____; Former District: _____

Coordination of Benefits

Do you or 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
Other Insurance Covers <input type="checkbox"/> Insured Only <input type="checkbox"/> Insured & Spouse <input type="checkbox"/> Insured & Dependents <input type="checkbox"/> Insured & Children						

COBRA Enrollment Only

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

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 WEA Select Plans cover registered domestic partners of any state or unregistered domestic partners who complete a domestic partner affidavit.

**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.

Underwritten by Washington Dental Service, 9706 4th Ave NE, Seattle, WA 98115-2157.

*Please send completed for to: Washington Dental Service
 Attn: Group Administration – WEA Team
 P.O. Box 75983 – Seattle, WA 98175-0983*

Signature _____ Date _____