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

WEA WASHINGTON EDUCATION ASSOCIATION

DeltaCare®
Enrollment Form
Washington Education Association

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

School District	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**
Spouse or Domestic Partner*				M ☐ F ☐	Add ☐ Remove ☐	
Dependent				M ☐ F ☐	Add ☐ Remove ☐	Incapacitated ☐
Dependent				M ☐ F ☐	Add ☐ Remove ☐	Incapacitated ☐
Dependent				M ☐ F ☐	Add ☐ Remove ☐	Incapacitated ☐
Dependent				M ☐ F ☐	Add ☐ Remove ☐	Incapacitated ☐

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

Other Insurance Covers
☐ Insured Only ☐ Insured & Spouse ☐ Insured & Dependents ☐ 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

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 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

WDS-DC-WEA-EF-0710