



# Enrollment Application

## Willamette Dental of Washington, Inc.

6950 NE CAMPUS WAY, HILLSBORO, OR 97124



**WEA**  
WASHINGTON  
EDUCATION  
ASSOCIATION

PLEASE TYPE OR PRINT - ALL ITEMS MUST BE COMPLETED

LAST NAME		FIRST NAME		M.	MALE	FEMALE	SOCIAL SECURITY NUMBER		
ADDRESS						HOME PHONE			
CITY		STATE		COUNTY		ZIP CODE		WORK PHONE	
EFFECTIVE DATE		SINGLE <input type="checkbox"/>		MAR. <input type="checkbox"/>		DIV. <input type="checkbox"/>		WIDOW(ER) <input type="checkbox"/>	
BIRTH DATE		DATE EMPLOYED		PLAN NAME					
NAME OF SCHOOL DISTRICT/ EMPLOYER			ADDRESS		CITY		STATE		ZIP CODE

CLASSIFICATION (CERTIF/ADMIN/CLASS/OTHER)				RELATIONSHIP CODES A - Natural Child      D - Step Child B - Legally Adopted    E - Domestic Partner C - Foster Child        F - Other (Explain)					
				MONTH	DATE OF BIRTH DAY	YEAR	MALE	SEX FEMALE	
LEGAL SPOUSE OR DOMESTIC PARTNER (FULL NAME)	SSN#	IS SPOUSE EMPLOYED? <input type="checkbox"/> NO <input type="checkbox"/> YES							
NAMES OF ALL CHILDREN	SSN#	DOES CHILD RESIDE WITH YOU? <input type="checkbox"/> NO <input type="checkbox"/> YES							
	SSN#	<input type="checkbox"/> NO <input type="checkbox"/> YES							
	SSN#	<input type="checkbox"/> NO <input type="checkbox"/> YES							
	SSN#	<input type="checkbox"/> NO <input type="checkbox"/> YES							

### Other Dental Plans

ARE YOU OR ANY OF YOUR DEPENDENTS COVERED BY ANOTHER DENTAL PLAN?  
 YES     NO    IF YES, NAME OF SUBSCRIBER: \_\_\_\_\_

NAME OF CARRIER \_\_\_\_\_ POLICY NUMBER \_\_\_\_\_

### Application/Authorization/Certification

I hereby apply for coverage through Willamette Dental of Washington, Inc. for myself and for my listed dependents. I am familiar with the terms of the coverage, including provisions dealing with emergencies, covered services through participating dentists and services which require copayments, payable by me or my dependents directly to the provider of such services.

I authorize my employer to make payroll deductions from my salary or wages in the amount required, if any, to cover my contribution to coverage with Willamette Dental of Washington, Inc.. I authorize any other provider of health services to give Willamette

Dental of Washington, Inc., upon request, any information concerning the health, condition, or treatment of any person included under such coverage whenever such information is considered necessary for the proper disposition of a claim in fulfillment of obligations imposed on Willamette Dental of Washington, Inc. by State or Federal law.

I certify that all information supplied in this application is true and complete to the best of my knowledge. I agree to advise Willamette Dental of Washington, Inc. of any change in status within 60 days from the date of change. Limited to two years within filing this form, I

understand that my membership is null and void if I have provided any information which is false or misleading regarding myself or my dependents on this form or any form filed in conjunction with this health plan.

**I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company or health care service contractor for the purpose of defrauding the company, and that penalties include imprisonment, fines and denial of insurance benefits.**

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
 MONTH      DAY      YEAR

### Employer Verification

### For WDWI Office Use Only

EMPLOYER/ADDRESS	REVIEWED BY	GROUP #	EFFECTIVE DATE
TELEPHONE	TITLE	ACCT TYPE	PROVIDER
SIGNATURE			