

## Application for Individual Dental Insurance

PLEASE TYPE OR PRINT IN BLACK INK ■ BE SURE APPLICATION IS COMPLETED IN FULL

**Customer Service: 1-800-286-1885**

**All Fields Are Required**

Last Name	First Name	Middle Initial	Gender: M/F
Home Address (mailing)	City	State	Zip
E-mail Address			Date of Birth
<small>By providing my e-mail address, I agree to receive my benefits policy and subsequent communications regarding my policy via e-mail. I may revoke this authorization at any time by writing to Washington Dental Service at the address supplied on the top of this application.</small>			
Reason for Application: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Change of Dependent(s)			
Plan Chosen: <input type="checkbox"/> Individual Plan <input type="checkbox"/> Individual Plan Plus			

PLEASE LIST ALL ELIGIBLE DEPENDENT(S) TO BE COVERED UNDER THIS POLICY					
Proof of eligibility for dependent coverage is not required upon application, but may be requested periodically.					
First Name	Last Name	Date of Birth	Relationship to Applicant (Spouse, Domestic Partner, or Dependent Child)	Gender M/F	Disabled Child Yes/No

### Prior Washington Dental Service Coverage

Have you had three months of dental coverage by Washington Dental Service in the past six months?  Yes  No

If yes, please provide your Social Security number or previous member ID: \_\_\_\_\_

*Washington Dental Service will verify previous coverage of enrollees. Upon validation, waiting periods may be waived.*

## Payment Instructions

A check may be submitted for the first payment on your policy. Thereafter, all premiums must be paid using Electronic Funds Transfer (EFT) from your checking (or savings) account. Payments will be withdrawn monthly.

### Please complete the following information for payment by EFT:

Name of Financial Institution \_\_\_\_\_

Financial Institution's City, State & ZIP Code \_\_\_\_\_

Type of Account (Choose one)  Checking  Savings Name on Account \_\_\_\_\_

Bank Routing Number \_\_\_\_\_ Bank Account Number \_\_\_\_\_

Please attach a voided check to this application if you will be using your checking account for automatic payments.

*I hereby authorize Washington Dental Service to initiate debit entries from my above bank account for my dental insurance premiums.*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

*Your monthly payment must be made by scheduled electronic withdrawal from your checking or savings account. Your monthly payment for the upcoming month will be deducted from your account on the 28th of each month or the next business day. If there are insufficient funds in your bank account for payment of premium on the due date, we will attempt to withdraw premiums for two months on the due date at the end of the next month. This constitutes a grace period of more than 20 days. If there are still insufficient funds, WDS will immediately terminate your contract for nonpayment of premium, effective as of the last day of the month for which payment was received.*

In making this application to Washington Dental Service (WDS) for dental coverage under this policy, I agree and understand that this application will become part of the policy and I agree to be bound by the terms of the policy issued by WDS. I further agree that the coverage requested is subject to the approval of WDS and that no representative has authority to make changes or modify this application for coverage.

I hereby certify that all of the information contained in this application is true and correct to the best of my knowledge. I further understand that misrepresentation of submitted data may cause this application and subsequent policy to be null and void. In the event it is discovered that you have provided false or misleading information in connection with this application for the purpose of defrauding WDS, WDS shall inform the appropriate state and regulatory authorities, including, but not limited to, the Washington State Office of the Insurance Commissioner (OIC). 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.

By my submission of this application I attest that I do not have other active dental coverage. If at any time I obtain other dental coverage, WDS reserves the right to terminate this plan with thirty (30) days notice.

Your policy will become effective on the first day of the month following approval of your application.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

**Coverage is contingent upon underwriting acceptance.**

**Please send the completed application to:**

**Washington Dental Service, Inc.**

P.O. Box 84885

Seattle, WA 98124-6185