DELTA DENTAL® Delta Dental of Washington

Application for Individual Dental and Vision Coverage

Please send completed application to:
Delta Dental of Washington
P.O. Box 103
Stevens Point, WI 54481
Fax: 800-807-1970

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

Customer Service: 888-899-3736
www.DeltaDentalCoversMe.com

Reason for Application: ☐ New Enrollment ☐ Change of Dependent(s)

Application Date: _____ **Coverage Start Date:** _____
Coverage will start on the first of the month. You may select which month your coverage begins, up to two months from the application date.

Section 1 | Plan Selection

Dental Plan Selection:

☐ Delta Dental – Premium Plan* ☐ Delta Dental – Plus Ortho Plan* ☐ Delta Dental – Ascent Plan*

☐ Delta Dental – Enhanced Plan* ☐ Delta Dental – Clear Plan ☐ Delta Dental – Basic Plan*

☐ Delta Dental – Optimum Plan*

*****_These plans require that the policyholder be a covered person. To learn more about these plans call 888-899-3736 or visit **www.DeltaDentalCoversMe.com.**_

Policies issued in the State of Washington are underwritten by Delta Dental of Washington, NAIC #47341, P.O. Box 75983, Seattle, WA 98115. All policies are administered, at least in part, by Wyssta Services, Inc.

Optional Vision Plan Selection:

☐ DeltaVision Essential 150 Plan ☐ DeltaVision Brilliance 200 Plan ☐ Waiving Vision Coverage

These plans require that the policyholder be a covered person on one of the above Dental Plans. To learn more about these plans call 888-899-3736 or visit **www.DeltaDentalCoversMe.com.**

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Section 2 | Policyholder Information

First Name	Middle Initial	Last Name	Date of Birth	Gender

Home Address (Mailing)	City	State	ZIP Code

Phone Number Is this a mobile number? ☐ Yes ☐ No	Email Address**	Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership

By providing my email address, I agree to receive communications regarding my Policy and benefits electronically. This authorization may be revoked on the website **www.DeltaDentalCoversMe.com or in writing to the address listed above.

Section 3 | Persons to be Covered

Please include yourself if applying for coverage under plans that require the policyholder to be covered

Name (First, Middle Initial, Last)	Relationship	Date of Birth	Gender	Disabled Child Y/N
	☐ Self ☐ Spouse or Domestic Partner*** ☐ Dependent Child			
	☐ Spouse or Domestic Partner*** ☐ Dependent Child			
	Dependent Child			
	Dependent Child			
	Dependent Child			

PRIOR DENTAL COVERAGE *(Please complete the following if you have had dental coverage within last 63 days)*
Applicable to determine your eligibility for a Waiting Period waiver

Previous Carrier	Beginning Coverage Date	Ending Coverage Date

Were all of the above persons covered by this dental plan in the past 63 days? ☐ Yes ☐ No

If no, please indicate the persons who did not have dental coverage within the past 63 day?

PRIOR ORTHODONTIC COVERAGE *(Please complete the following if your prior dental plan had orthodontic coverage for 12 continuous months)* **Only applicable if you selected the Delta Dental – Plus Ortho Plan**

Previous Carrier	Beginning Coverage Date	Ending Coverage Date

Were all of the above persons covered for Orthodontic coverage by this dental plan in the past 63 days? ☐ Yes ☐ No

If no, please indicate the persons who did not have orthodontic coverage within the past 63 day?

****In Washington State, references to Married or Spouse apply equally to same-sex and opposite-sex spouse and to both registered and unregistered domestic partnerships.*

Section 4 | Payment Instructions

To calculate rates please visit **www.DeltaDentalCoversMe.com** or call 888-899-3736.

A debit card, credit card or EFT (Electronic Funds Transfer) may be used to pay monthly, semi-annually or annually. If paying by check, remittance for the full annual 12-month premium is required, payable to Delta Dental of Washington.

Choose payment method: ☐ Debit/Credit Card ☐ EFT/ACH ☐ Annual Check

Applications received on or after the 25th of the month must use a credit card if requesting a first of the following month effective date. If EFT payment is selected, your effective date will be adjusted to the first of the next month. After enrollment, your payment type can be changed by logging in to www.DeltaDentalCoversMe.com or by calling 1-888-899-3734.

Payment Frequency: ☐ Monthly ☐ Semi-annually ☐ Annually

Please complete the following information for payment by Annual Check:

Please send payment to: Delta Dental of Washington P.O Box 103, Stevens Point, WI 54481

Please complete the following information for payment by Debit/Credit Card:

Card Type: ☐ Visa ☐ MasterCard ☐ Discover

Cardholder Name:_____

Cardholder Address:_____

City:_____ State/ZIP:_____

Card Number:_____

Expiration Date (MM/YYYY): _____ Security Code (from back of card):_____

Please complete the following information for payment by EFT/ACH:

Type of Account (Choose One): ☐ Checking ☐ Savings

Name of Financial Institution:_____

Institution's City, State & ZIP Code:_____

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 authorize Delta Dental of Washington to initiate debit entries from my above bank account or Debit/Credit card for my premiums.

Signature:_____ Date:_____

Your initial payment is due when the application is processed. Additional payments for upcoming periods will be deducted from your account on the month prior to its due date. If the charge is declined for any reason, we will attempt to charge you again the following month. If the charge is still declined, we will immediately terminate your contract for nonpayment of premium, effective as of the last day of the month for which premiums were paid.

In submitting this application to Delta Dental of Washington for dental coverage and/or vision coverage, if selected, I agree and understand that this application will become part of the dental and/or vision Policy and I agree to be bound by the terms of the any dental or vision Policy issued by Delta Dental of Washington. I understand that this is a contract under which I am obligated to pay premium for the term of the contract. I further agree that the coverage requested is subject to the approval of DDWA and that no representative has authority to make changes or modify this application for coverage.

I 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 I have provided false or misleading information in connection with this application for the purpose of defrauding Delta Dental of Washington, DDWA shall inform the appropriate state and regulatory authorities, including, but not limited to, my state's insurance commissioner. 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.

_____ _____

Policyholder Signature **Date**

Coverage is contingent upon underwriting acceptance

Producer Use Only	*Producer Name or Code:*		*Producer #:*	
Commission payment may not be supported for all products. Please contact Delta Dental of Washington for more information.				