Dental Enrollment Application and Change of Information Form

You must complete this enrollment form to participate in the dental plan

Willamette Dental of Washington, Inc.

TYPE OF APPLICATION: ☐ New Application ☐ Change of Information

☐ COBRA* ☐ 18 Months ☐ 29 Months ☐ 36 Months *Continuation Qualifying Event Date:_____

PLEASE TYPE OR PRINT - PRESS FIRMLY - 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 ☐	MAR. ☐	DIV. ☐	WIDOW(ER) ☐	BIRTH DATE	OCCUPATION	DATE EMPLOYED FULL TIME	PLAN NAME

NAME OF EMPLOYER	ADDRESS	CITY	STATE	ZIP CODE

☐ I AM ENROLLING MYSELF ONLY ☐ I AM ENROLLING MYSELF & DEPENDENTS (LIST DEPENDENTS INFORMATION BELOW)

RELATIONSHIP CODES
A - Natural Child
B - Legally Adopted
C - Foster Child
D - Step Child
E - Domestic Partner
F - Other (Explain)

			DATE OF BIRTH MONTH	DAY	YEAR	SEX MALE	FEMALE
LEGAL SPOUSE (FULL NAME)	SSN#	IS SPOUSE EMPLOYED? ☐ NO ☐ YES					
NAMES OF ALL CHILDREN	SSN#	DOES CHILD RESIDE WITH YOU? ☐ NO ☐ YES					
	SSN#	☐ NO ☐ YES					
	SSN#	☐ NO ☐ YES					
	SSN#	☐ NO ☐ YES					

IMPORTANT: IF YOU ARE ENROLLING A DEPENDENT CHILD AGE 19 OR OLDER, COMPLETE THE STUDENT INFORMATION ON THE REVERSE SIDE.

To change enrollment information, please provide the appropriate information below.

☐ Change Address - Complete address section on reason line below.
☐ Add Dependent - Complete dependent section and note reason and effective date on reason line below.
☐ Delete Dependent - Complete dependent section and note reason and effective date on reason line below.
☐ Name Change - Note effective date and old/new names on the reason line below.
☐ Termination ☐ Open Enrollment

Reason:_____

Other Dental Plans

ARE YOU OR ANY OF YOUR DEPENDENTS COVERED BY ANOTHER DENTAL PLAN?
☐ YES ☐ NO IF YES, NAME OF MEMBER:

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 co-payments, 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

WILLAMETTE DENTAL®

PLEASE TYPE OR PRINT - PRESS FIRMLY - ALL ITEMS MUST BE COMPLETED

Employer Verification

EMPLOYER/ADDRESS

TELEPHONE | REVIEWED BY

SIGNATURE | TITLE

For Office Use Only

GROUP # | EFFECTIVE DATE

ACCT TYPE | PROVIDER

Student Information

STUDENT NAME	INSTITUTION/SCHOOL	DATE OF ATTENDANCE

* Verification of full-time school attendance may be required

Waiver Of Group Dental Insurance

LAST NAME | FIRST NAME | M.

NAME OF EMPLOYER

I HEREBY WAIVE THE RIGHT TO GROUP DENTAL INSURANCE OFFERED THROUGH MY EMPLOYER.

☐ EMPLOYEE & DEPENDENTS

☐ DEPENDENTS ONLY

SIGNATURE | DATE