



**Application for Large Group Dental Coverage**  
 Willamette Dental of Washington, Inc.  
 6950 NE Campus Way  
 Hillsboro, OR 97124  
 Toll Free: (800) 360-1909  
 Fax: (360) 459-4348

REQUESTED EFFECTIVE DATE: \_\_\_\_\_

**GROUP INFORMATION**

Applicant - Full Legal Name: \_\_\_\_\_  
*Exactly as it is to be shown in the contract.*

Tax ID #: \_\_\_\_\_ Affiliates, if any\*: \_\_\_\_\_  
*\*Attach separate page if more than one.*

Type of Business: \_\_\_\_\_

**PHYSICAL ADDRESS**

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

**MAILING ADDRESS (if different from Physical Address)**

Address or PO Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**INDEMNITY CARRIER, IF ANY**

Name: \_\_\_\_\_

**GROUP CONTACT INFORMATION**

Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

**ELIGIBILITY CONTACT INFORMATION**

Billing/Eligibility Contact Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

**ELECTRONIC ELIGIBILITY TRANSFER**

Indicate monthly Billing/Eligibility Transfer (**Check one**):  Electronic  Hard Copy  **WHIT**

If electronic transfer, please fill in information for A, B, & C below:

- A. Who will send data? (Group, Broker, TPA, etc): WHIT Zenith Administrators, Inc.
- B. Electronic data format:  Standard 834  Willamette Dental 302 Format
- C. How will data be sent? (E-mail, Web, FTP, etc.): \_\_\_\_\_

**COVERAGE REQUESTED**

Employee, Spouse, & Children

Domestic Partners

**EMPLOYEES**

Total number of Eligible Employees (including full and part-time): \_\_\_\_\_

Total number of Enrolled Employees: \_\_\_\_\_

Weekly hours required to be an Eligible Employee: \_\_\_\_\_

Employees will be eligible for coverage on the first day of the month following or coinciding with \_\_\_\_\_ consecutive days of employment as an Eligible Member.

**PREMIUM PERCENTAGE EMPLOYER CONTRIBUTES**

Member: \_\_\_\_\_ % Dependents: \_\_\_\_\_ % Retirees: \_\_\_\_\_ %

**DEPENDENT CHILD AGES**

Dependent age is from birth through age 24.

\* Unless otherwise requested \_\_\_\_\_

**ID CARDS & CERTIFICATES OF COVERAGE**

Send ID cards to:  Employer at initial billing **OR**  Directly to individual Members

Send Certificates of Coverage:  via E-mail **OR**  Hard Copy

**COBRA & ERISA INFORMATION**

Offering Plan to COBRA Members:  Yes  No

Who administers your COBRA:  Group  TPA

\*If "TPA," Name of Administrator: \_\_\_\_\_

Is the Group subject to ERISA:  Yes  No

*Please provide the ERISA information **only** if the Group wishes to include ERISA in their Certificate of Coverage:*

Plan Number: \_\_\_\_\_ (Must be a three digit number beginning with 5)

Fiscal Year End: \_\_\_\_\_

Plan Administrator: \_\_\_\_\_  
(if different from Group information)

Registered Agent of Legal Process: \_\_\_\_\_  
(if different from Group information)

