DELTA DENTAL®
Washington Dental Service
Washington Dental Service is a member of the Delta Dental Plans Association

WEA WASHINGTON EDUCATION ASSOCIATION

Enrollment Form

Washington Education Association

☐ New Hire ☐ Change ☐ Open Enrollment ☐ COBRA ☐ Reinstate ☐ Other (Check One)

Employer complete this section:

Group Number _____ Subgroup _____

Please indicate current dental rate $_____ and your WEA Dental Plan #_____ and Ortho if applicable _____

School District			Hire Date	Effective Date	
Social Security Number	First Name	Middle Initial	Last Name	Birthdate	Gender
Address		City	State	Zip	
Phone Number		Email Address			

Dependents

Please list all dependents to be covered:

First Name	Middle Initial	Last Name	Birthdate	Gender	Add/ Remove	Dependent Over Limiting Age Verification**
Spouse or Domestic Partner*				M ☐ F ☐	Add ☐ Remove ☐	
Dependent				M ☐ F ☐	Add ☐ Remove ☐	Incapacitated ☐
Dependent				M ☐ F ☐	Add ☐ Remove ☐	Incapacitated ☐
Dependent				M ☐ F ☐	Add ☐ Remove ☐	Incapacitated ☐
Dependent				M ☐ F ☐	Add ☐ Remove ☐	Incapacitated ☐

Incentive Level Transfer Information

WEA Select Dental Plan? Yes ☐ No ☐

WDS: _____; Willamette: _____; # of Years:_____; Former District:_____

Coordination of Benefits

Do you or any of your dependents have other dental coverage? Yes ☐ No ☐ If yes, please complete the section below.

Employer Group Number and Name			Effective Date		
Name and Address of Other Insurance Carrier					
Social Security Number	First Name	Middle Initial	Last Name	Birthdate	Gender
Other Insurance Covers ☐ Insured Only ☐ Insured & Spouse ☐ Insured & Dependents ☐ Insured & Children					

COBRA Enrollment Only

Indicate Qualifying Date
Indicate Qualifying Event ☐ Termination ☐ Reduction in Hours ☐ Divorce ☐ Widowed/Surviving Dependent ☐ Dependent Child No Longer Eligible ☐ Other

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 (R.C.W. 48.135.080).

* The WEA Select Plans cover registered domestic partners of any state or unregistered domestic partners who complete a domestic partner affidavit.

** Documentation is required (pursuant to R.C.W. 48.44.210). To download the proof of incapacity and dependency form, visit the Washington Dental Service Web site at **www.DeltaDentalWA.com/forms.**

Underwritten by Washington Dental Service, 9706 4th Ave NE, Seattle, WA 98115-2157.

Please send completed for to: Washington Dental Service
Attn: Group Administration — WEA Team
P.O. Box 75983 — Seattle, WA 98175-0983

_____
Signature Date

WDS-WEA-EF-0810