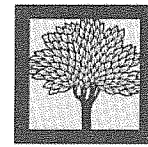




Enrollment Application

Willamette Dental of Washington, Inc.

6950 NE CAMPUS WAY, HILLSBORO, OR 97124



WEA

WASHINGTON
EDUCATION
ASSOCIATION

Type of Application New Change of Information

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

PLEASE TYPE OR PRINT - 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
<input type="checkbox"/> SINGLE	<input type="checkbox"/> MAR.	<input type="checkbox"/> DIV.	<input type="checkbox"/> WIDOW(ER)	BIRTH DATE		DATE EMPLOYED		PLAN NAME	
NAME OF SCHOOL DISTRICT/ EMPLOYER			ADDRESS			CITY		STATE	ZIP CODE

CLASSIFICATION (CERTIF/ADMIN/CLASS/OTHER)				RELATIONSHIP CODES A - Natural Child D - Step Child B - Legally Adopted E - Domestic Partner C - Foster Child F - Other (Explain)					
				MONTH	DATE OF BIRTH DAY	YEAR	MALE	SEX FEMALE	
LEGAL SPOUSE OR DOMESTIC PARTNER (FULL NAME)	SSN#	IS SPOUSE EMPLOYED? <input type="checkbox"/> NO <input type="checkbox"/> YES							
NAMES OF ALL CHILDREN	SSN#	DOES CHILD RESIDE WITH YOU? <input type="checkbox"/> NO <input type="checkbox"/> YES							
	SSN#	<input type="checkbox"/> NO <input type="checkbox"/> YES							
	SSN#	<input type="checkbox"/> NO <input type="checkbox"/> YES							
	SSN#	<input type="checkbox"/> NO <input type="checkbox"/> YES							

Other Dental Plans

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

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 copayments, payable by me or my dependents directly to the provider of such services.

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.

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 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

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

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

Employer Verification

For WDWI Office Use Only

EMPLOYER/ADDRESS	REVIEWED BY	GROUP #	EFFECTIVE DATE
TELEPHONE	SIGNATURE	ACCT TYPE	PROVIDER
	TITLE		