

Washington Dental Service

Enrollment Form

New
 Change
 Open Enrollment
 COBRA
 Other

1.

Employer or Group Name	Group Number	Sub Group	Hire Date	Effective Date
Last Name		First Name		Middle
SSN	Birthdate	Phone Number		
Address		City	State	Zip

Please list all dependents to be covered.

Spouse

					WDS use only		
Last Name	First Name	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>	Birthdate		Deductible	Incentive

Dependents

					<small>Check below if dependent is over age, a full-time student or incapacitated.</small>	<small>WDS use only</small>	
Last Name	First Name	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>	Birthdate	<input type="checkbox"/> FT Student <input type="checkbox"/> Incapacitated <input type="checkbox"/> Primarily Dependent	Deductible	Incentive
Last Name	First Name	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>	Birthdate	<input type="checkbox"/> FT Student <input type="checkbox"/> Incapacitated <input type="checkbox"/> Primarily Dependent	Deductible	Incentive
Last Name	First Name	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>	Birthdate	<input type="checkbox"/> FT Student <input type="checkbox"/> Incapacitated <input type="checkbox"/> Primarily Dependent	Deductible	Incentive
Last Name	First Name	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>	Birthdate	<input type="checkbox"/> FT Student <input type="checkbox"/> Incapacitated <input type="checkbox"/> Primarily Dependent	Deductible	Incentive

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.

Signature _____

Date _____

2. Coordination of Benefits

Do any of your dependents have other dental coverage? Y N If yes, please complete the section below

SSN	Last Name	First	Middle	Birthdate
Name and Address of other insurance carrier				
Employer group number and name			Effective Date	

3. COBRA Enrollment if other than Employee

COBRA state qualifying event	Effective Date	Relationship to above named subscriber <input type="checkbox"/> Spouse <input type="checkbox"/> Over age dependent <input type="checkbox"/> Other		
SSN	Last Name	First Name	Middle	Birthdate

Dependents

					<small>Check below if dependent is over age, a full-time student or incapacitated.</small>	<small>WDS use only</small>	
Last Name	First Name	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Add <input type="checkbox"/> Remove <input type="checkbox"/>	Birthdate	<input type="checkbox"/> FT Student <input type="checkbox"/> Incapacitated <input type="checkbox"/> Primarily Dependent	Deductible	Incentive
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Date _____

Disclosure Information

In accordance with section 4 of ESSB 6392, Chapter 312, Laws of 1996, the Managed Care Entities Disclosure Act, WDS is pleased to provide important information about our various dental care plans. The goal of this law is to provide individuals who are making health care decisions for themselves and their families with as much information as possible to make the best decisions. Washington Dental Service fully supports this principle and supplies most of the required information in enrollee benefit booklets, which are supplied to each enrollee at the start of their coverage.

The items of information which you may request Washington Dental Service to provide you are:

- 1a) the availability of a point of service plan and how the plan operates within the coverage
 - 1b) documents, instruments or other information referred to in the enrollment agreement
 - 1c) procedures to be followed for consulting a provider other than the primary care provider
(applies primarily to capitation plans)
 - 1d) existence of plan list or formulary for prescription drugs, for plans with that specific benefit
 - 1e) procedures that must be followed for obtaining prior authorization for health care services
 - 1f) reimbursement or payment arrangements, between a carrier and a provider
 - 1g) circumstances under which a plan may retrospectively deny coverage for care that had prior authorization
 - 1h) copy of all grievance procedures for claim or service denial and for dissatisfaction with care
 - 1i) description and justification for provider compensation programs, including any incentive or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists
- 2) Enrollees of Washington Dental Service dental care plans may, at any time, freely contract to obtain other forms of dental care or health care services outside Washington Dental Service plan coverage for any reason they choose, however, the enrollee must pay for all such services.

In order to obtain this information, you must call 1-800-367-4104. A Washington Dental Service employee will take your name and send you the information you requested. If you are an enrollee of a dental care plan with Washington Dental Service, we may also refer you to your benefit booklet for additional information about your plan that may be useful. You can also write Washington Dental Service and request the above information at P.O. Box 75983, Seattle, WA 98175-0983.