



# Washington Dental Service

## ENROLLMENT FORM

NEW   
  CHANGE   
  OPEN ENROLLMENT   
  COBRA   
  OTHER

EMPLOYER OR GROUP NAME		GROUP NUMBER	HIRE DATE	EFFECTIVE DATE
SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	MI	BIRTHDATE MO   DY   YR
ADDRESS		CITY	STATE	ZIP CODE
PLEASE LIST ALL DEPENDENTS TO BE COVERED. DEPENDENTS MUST BE ELIGIBLE AS INCOME TAX DEPENDENTS		BIRTHDATE MO   DY   YR	<input checked="" type="checkbox"/>	CHECK IF DEPENDENT IS OVERAGE OR INCAPACITATED LIST NAME AND YEAR OF SCHOOL
LAST NAME FIRST NAME				WDS USE ONLY
SPOUSE			SPOUSE: PLEASE INCLUDE DATE OF MARRIAGE.	DEDUCTIBLE   INCENTIVE
DEPENDENT				
DEPENDENT				
DEPENDENT				
DEPENDENT				
SIGNATURE		DATE:		
X				

### C.O.B. (coordination of benefits) INFORMATION

DO YOU OR ANY OF YOUR DEPENDENTS HAVE OTHER DENTAL COVERAGE?  YES  NO IF YES, COMPLETE SECTION BELOW

SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	MI	BIRTHDATE MO   DY   YR
NAME AND NUMBER OF OTHER INSURANCE:				
ADDRESS OF OTHER CARRIER:				
EMPLOYER OF INSURED:				
OTHER INSURANCE COVERS <input type="checkbox"/> INSURED ONLY <input type="checkbox"/> INSURED & SPOUSE <input type="checkbox"/> INSURED & DEPENDENTS <input type="checkbox"/> INSURED & CHILDREN				

### COBRA ENROLLMENT IF OTHER THAN EMPLOYEE

COBRA STATE QUALIFYING EVENT: \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_

RELATIONSHIP TO ABOVE NAMED SUBSCRIBER  SPOUSE  OVERAGE DEPENDENT  OTHER

SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	MI	BIRTHDATE MO   DY   YR
LIST DEPENDENTS TO BE COVERED UNDER COBRA BENEFITS:		BIRTHDATE MO   DY   YR	<input checked="" type="checkbox"/>	CHECK IF DEPENDENT IS OVERAGE OR INCAPACITATED LIST NAME AND YEAR OF SCHOOL
LAST NAME FIRST NAME				WDS USE ONLY
DEPENDENT				DEDUCTIBLE   INCENTIVE
DEPENDENT				
DEPENDENT				
DEPENDENT				
SIGNATURE		DATE:		
X				

WHITE - WDS      YELLOW - EMPLOYER      PINK - EMPLOYEE