

Dental Enrollment Application and Change of Information Form

Willamette Dental of Washington, Inc.
6950 NE Campus Way, Hillsboro, Oregon 97124



Willamette
Dental Group

Please print your answers clearly in ink and fill out both sides of this form so we can process your application quickly. Thank you.

1 I'm filling out this application because I am...

- a new applicant
 a current member: (select a box below)
 a COBRA member: (select a box below)
- a retiree
 changing my name
 18 months
 changing my address
 29 months
 changing my dependents
 36 months
 terminating my coverage
 Date of Continuation Qualifying
 due to...
 Event: Entered Access
 open enrollment
 qualifying event (marriage, adoption, birth, loss of other coverage)
 Date of qualifying event: _____

2 My employer information is...

Name of Dental Group Bremerton Metal Trades Council	Group ID# WA-27	Effective Date	
Address P.O. Box 448	City Bremerton	State WA	Zip Code 98337
Work phone #	Occupation	Date of Hire	

3 My Information is:

Last, First, MI	SSN	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Mailing Address	City, State & Zip	Personal Phone #
Personal Email Address	Date of Birth	Previous Name

4 I want to enroll my:

Spouse or Domestic Partner	SSN	Gender <input type="checkbox"/> M <input type="checkbox"/> F
	Date of Birth	<input type="checkbox"/> Husband/Wife <input type="checkbox"/> Dom. Part. <input type="checkbox"/> Add <input type="checkbox"/> Delete
Dependent Child	SSN	Gender <input type="checkbox"/> M <input type="checkbox"/> F
	Date of Birth	<input type="checkbox"/> Add <input type="checkbox"/> Delete
Dependent Child	SSN	Gender <input type="checkbox"/> M <input type="checkbox"/> F
	Date of Birth	<input type="checkbox"/> Add <input type="checkbox"/> Delete
Dependent Child	SSN	Gender <input type="checkbox"/> M <input type="checkbox"/> F
	Date of Birth	<input type="checkbox"/> Add <input type="checkbox"/> Delete



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Additional dependents...

Dependent Child	SSN	Gender <input type="checkbox"/> M <input type="checkbox"/> F
	Date of Birth	<input type="checkbox"/> Add <input type="checkbox"/> Delete
Dependent Child	SSN	Gender <input type="checkbox"/> M <input type="checkbox"/> F
	Date of Birth	<input type="checkbox"/> Add <input type="checkbox"/> Delete
Dependent Child	SSN	Gender <input type="checkbox"/> M <input type="checkbox"/> F
	Date of Birth	<input type="checkbox"/> Add <input type="checkbox"/> Delete

6

Other dental insurance I have...

Are you or any of your dependents are covered by another dental plan?

Yes No

If yes, name of enrollee: _____

Name of Carrier: _____ Policy Number: _____

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Signatures

I hereby apply for coverage through Willamette Dental of Washington, Inc. for myself and for my listed dependents.

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 provider of health services to give Willamette 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.

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 understand that my coverage 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 plan.

I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company, and that penalties include imprisonment, fines and denial of insurance benefits.

Signature of Primary Applicant	Date of Signature
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Waiving your group dental insurance...

Do you wish to waive the right to group dental insurance offered through your employer?

Yes No

If yes, please choose who you are waiving coverage for below:

Myself & my dependents My dependents only

Signature: _____ Date: ____ / ____ / ____