



ENROLLMENT FORM

NEW CHANGE OPEN ENROLLMENT COBRA REINSTATE OTHER

Employer Complete this Section:				
Please Indicate Current Dental Rate \$ _____ or your WEA Dental Plan # & Ortho if applicable _____				
SCHOOL DISTRICT 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			CHECK IF DEPENDENT INCAPACITATED	
			Add <input type="checkbox"/> Remove <input type="checkbox"/>	Birthdate (MO/DY/YR)
			Add <input type="checkbox"/> Remove <input type="checkbox"/>	Gender (M/F)
LAST NAME				
FIRST NAME				
EMPLOYEE			Add <input type="checkbox"/> Remove <input type="checkbox"/>	
SPOUSE <small>PLEASE INCLUDE DATE OF MARRIAGE</small>			Add <input type="checkbox"/> Remove <input type="checkbox"/>	
DEPENDENT			Add <input type="checkbox"/> Remove <input type="checkbox"/>	
DEPENDENT			Add <input type="checkbox"/> Remove <input type="checkbox"/>	
DEPENDENT			Add <input type="checkbox"/> Remove <input type="checkbox"/>	
DEPENDENT			Add <input type="checkbox"/> Remove <input type="checkbox"/>	
WEA/WDS Incentive Dental (Group #186): ___ Yes ___ No If yes, # of years ___ & Former District _____				
Transfer from Willamette Dental Plan: ___ Yes ___ No If yes, # of years on the plan _____				
COB (Coordination of Benefits) INFORMATION				
DO YOU OR ANY OF YOUR DEPENDENTS HAVE OTHER DENTAL COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, COMPLETE SECTION BELOW				
SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	MI	BIRTH DATE (MO/DY/YR)
NAME AND ADDRESS OF OTHER INSURANCE CARRIER				
EMPLOYER GROUP NUMBER AND NAME				EFFECTIVE DATE (MO/DY/YR)
ARE ANY DEPENDENTS STEP CHILDREN? <input type="checkbox"/> YES <input type="checkbox"/> NO				
DOES THE INSURANCE COVER: <input type="checkbox"/> INSURED ONLY <input type="checkbox"/> INSURED & SPOUSE <input type="checkbox"/> INSURED & ALL DEPENDENTS <input type="checkbox"/> INSURED & CHILDREN ONLY				
COBRA ENROLLMENT IF OTHER THAN EMPLOYEE				
STATE QUALIFYING EVENT: _____				EFFECTIVE DATE: _____
RELATIONSHIP TO ABOVE NAMED SUBSCRIBER <input type="checkbox"/> SPOUSE <input type="checkbox"/> OVERAGE DEPENDENT <input type="checkbox"/> OTHER				
SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	MI	BIRTH DATE (MO/DY/YR)
LIST DEPENDENTS TO BE COVERED UNDER COBRA BENEFITS:			CHECK IF DEPENDENT IS INCAPACITATED	
			Add <input type="checkbox"/> Remove <input type="checkbox"/>	Birthdate (MO/DY/YR)
LAST NAME				
FIRST NAME				
DEPENDENT			Add <input type="checkbox"/> Remove <input type="checkbox"/>	
DEPENDENT			Add <input type="checkbox"/> Remove <input type="checkbox"/>	
DEPENDENT			Add <input type="checkbox"/> Remove <input type="checkbox"/>	
DEPENDENT			Add <input type="checkbox"/> Remove <input type="checkbox"/>	
RELEASE AND AUTHORIZATION I hereby verify that all of the information specified above is accurate and complete. I have also read and understand the Application Agreement and Release of Information provisions.				
EMPLOYEE SIGNATURE				DATE

Please send completed form to: Washington Dental Service
Attn: Group Administration - WEA Team
PO Box 75983
Seattle, WA 98175-0983

In accordance with section 4 of ESSB 6392, Chapter 312, Laws of 1996, the Managed Care Entities Disclosure Act, Washington Dental Service (WDS) is pleased to provide important information about our various dental care plans. The goal of this new 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. WDS 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 WDS to provide you are:

- The availability of a point of service plan and how the plan operates within the coverage
- Documents, instruments or other information referred to in the enrollment agreement
- Procedures to be followed for consulting a provider other than the primary care provider (applies primarily to capitation plans)
- Existence of plan list or formulary for prescription drugs, for plans with that specific benefit
- Procedures that must be followed for obtaining prior authorization for health care services
- Reimbursement or payment arrangements, between a carrier and a provider
- Circumstances under which a plan may retrospectively deny coverage for care that had prior authorization
- Copy of all grievance procedures for claim or service denial and for dissatisfaction with care
- 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
- Enrollees of WDS dental care plans may, at any time, freely contract to obtain other forms of dental care or health care services outside WDS 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 WDS employee will take your name and send you the information you requested. If you are an enrollee of a dental care plan with WDS, we may also refer you to your benefit booklet for additional information about your plan that may be useful. You can also write WDS and request the above information at PO Box 75983, Seattle, WA 98175-0983, Attn: Customer Service.