DENTAL ENROLLMENT APPLICATION
AND CHANGE OF INFORMATION FORM

Willamette Dental of Washington, Inc., 6950 NE Campus Way, Hillsboro, OR 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 retiree

☐ a current member who is: (*select a box below*)
☐ changing my name ☐ changing my address ☐ changing my dependents ☐ terminating my coverage
Due to: ☐ open enrollment ☐ qualifying event (marriage, adoption, birth, loss of their coverage)
Date of qualifying event: _____

☐ a COBRA member: (*select a box below*)
☐ 18 months ☐ 29 months ☐ 36 months
Date of Continuation Qualifying Event: _____

2. MY EMPLOYER INFORMATION IS...

Name of Employer:	Group ID:	Effective Date:	
Work Address:	City:	State:	Zip:
Work Telephone Number:	Occupation:	Date of Hire:	

3. MY INFORMATION IS...

Name (Last, First, Middle Initial)	Social Security Number:	Gender:
Home Address:	City/State/Zip:	Telephone Number:
E-mail Address:	Date of Birth:	Previous Name, if applicable:

4. I WANT TO ENROLL MY...

Legal Spouse or Domestic Partner Name (Last, First, MI)	Social Security Number		Gender
	Date of Birth	☐ Spouse ☐ Domestic Partner	☐ Add ☐ Remove
Dependent Child Name (Last, First, MI)	Social Security Number		Gender
	Date of Birth		☐ Add ☐ Remove
Dependent Child Name (Last, First, MI)	Social Security Number		Gender
	Date of Birth		☐ Add ☐ Remove

Please continue application on back...

5. ADDITIONAL DEPENDENTS...

Dependent Child Name (Last, First, MI)	Social Security Number	Gender
	Date of Birth	☐ Add ☐ Remove
Dependent Child Name (Last, First, MI)	Social Security Number	Gender
	Date of Birth	☐ Add ☐ Remove
Dependent Child Name (Last, First, MI)	Social Security Number	Gender
	Date of Birth	☐ Add ☐ Remove

6. OTHER DENTAL INSURANCE I HAVE...

Are you or any of your dependents covered by another dental plan? ☐ Yes ☐ No

If yes, name of enrollee: _____

Name of Carrier: _____ Policy Number: _____

7. 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 _____

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: ☐ Myself & my dependents ☐ My dependents only

Signature of Primary Applicant _____ Date of Signature _____