# Dental Enrollment Application
## and Change of Information Form

Willamette Dental Insurance, 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 retiree

☐ a current member: (select a box below)
- ☐ changing my name
- ☐ changing my address
- ☐ changing my dependents
- ☐ terminating my coverage

due to...
- ☐ open enrollment
- ☐ qualifying event - Type of qualifying event: _____
  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 | |
|---|---|---|---|
| Address | City | State | Zip Code |
| Work Telephone Number | Occupation | Date of Hire | |

### 3 My information is...

| **Self** (Last, First, Middle Initial) | Social Security Number | Gender ☐ M ☐ F |
|---|---|---|
| Home Address | City/State/Zip | Home Telephone Number |
| E-mail Address | Date of Birth / / | Old Name, if applicable |

### 4 I want to enroll my...

| **Legal Spouse or Domestic Partner** (Last, First, Middle Initial) | Social Security Number | Gender ☐ M ☐ F |
|---|---|---|
| | Date of Birth / / ☐ Husband/Wife ☐ Dom. Part. | ☐ Add ☐ Delete |
| **Dependent Child** (Last, First, Middle Initial) | Social Security Number | Gender ☐ M ☐ F |
| | Date of Birth / / | ☐ Add ☐ Delete |
| **Dependent Child** (Last, First, Middle Initial) | Social Security Number | Gender ☐ M ☐ F |
| | Date of Birth / / | ☐ Add ☐ Delete |
| **Dependent Child** (Last, First, Middle Initial) | Social Security Number | Gender ☐ M ☐ F |
| | Date of Birth / / | ☐ Add ☐ Delete |



**Please continue application on back...**

# Dental Enrollment Application Continued...

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## 5 Additional dependents...

| | | |
|---|---|---|
| **Dependent Child** (Last, First, Middle Initial) | Social Security Number | Gender ☐ M ☐ F |
| | Date of Birth / / | ☐ Add ☐ Delete |
| **Dependent Child** (Last, First, Middle Initial) | Social Security Number | Gender ☐ M ☐ F |
| | Date of Birth / / | ☐ Add ☐ 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: _____

## 7 Signatures

I hereby apply for coverage through Willamette Dental Insurance, 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 Insurance, Inc. I authorize any provider of health services to give Willamette Dental Insurance, 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 Insurance, 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 Insurance, 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 may be 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.

| 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 below:

☐ Myself & my dependents ☐ My dependents only

Signature: _____ Date: ___/___/_____