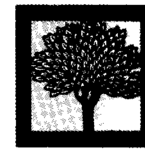
Enrollment Application

Willamette Dental of Washington, Inc.

6950 NE CAMPUS WAY, HILLSBORO, OR 97124



WEA
WASHINGTON EDUCATION ASSOCIATION

Type of Application ❑ New ❑ Change of Information

❑ COBRA ❑ 18 Months ❑ 29 Months ❑ 36 Months * Continuation Qualifying Event Date:______________

PLEASE TYPE OR PRINT - ALL ITEMS MUST BE COMPLETED

LAST NAME	FIRST NAME	M.	MALE	FEMALE	SOCIAL SECURITY NUMBER

ADDRESS	HOME PHONE

CITY	STATE	COUNTY	ZIP CODE	WORK PHONE	EFFECTIVE DATE

SINGLE ☐	MAR. ☐	DIV. ☐	WIDOW(ER) ☐	BIRTH DATE	DATE EMPLOYED	PLAN NAME	

NAME OF SCHOOL DISTRICT/ EMPLOYER	ADDRESS	CITY	STATE	ZIP CODE

CLASSIFICATION (CERTIF/ADMIN/CLASS/OTHER)

RELATIONSHIP CODES
A - Natural Child
B - Legally Adopted
C - Foster Child
D - Step Child
E - Domestic Partner
F - Other (Explain)

	SSN#		RELATIONSHIP CODE	DATE OF BIRTH MONTH	DAY	YEAR	SEX MALE	FEMALE
LEGAL SPOUSE OR DOMESTIC PARTNER (FULL NAME)	SSN#	IS SPOUSE EMPLOYED? ☐ ☐						
NAMES OF ALL CHILDREN	SSN#	DOES CHILD RESIDE WITH YOU? ☐ NO ☐ YES						
	SSN#	☐ NO ☐ YES						
	SSN#	☐ NO ☐ YES						
	SSN#	☐ NO ☐ YES						

Other Dental Plans

ARE YOU OR ANY OF YOUR DEPENDENTS COVERED BY ANOTHER DENTAL PLAN?
☐ YES ☐ NO IF YES, NAME OF SUBSCRIBER:

NAME OF CARRIER POLICY NUMBER

Application/Authorization/Certification

I hereby apply for coverage through Willamette Dental of Washington, Inc. for myself and for my listed dependents. I am familiar with the terms of the coverage, including provisions dealing with emergencies, covered services through participating dentists and services which require copayments, payable by me or my dependents directly to the provider of such services.

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 other 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 membership 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 health plan.

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

SIGNATURE DATE
MONTH DAY YEAR

Employer Verification

EMPLOYER/ADDRESS

TELEPHONE REVIEWED BY

SIGNATURE TITLE

For WDWI Office Use Only

GROUP # EFFECTIVE DATE

ACCT TYPE PROVIDER