

# 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 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  
 due to...     
 Date of Continuation Qualifying Event: \_\_\_\_\_  
 open enrollment  
 qualifying event - Type of qualifying event: \_\_\_\_\_  
 Date of 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 <input type="checkbox"/> M <input type="checkbox"/> 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 <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 (Last, First, Middle Initial)	Social Security Number	Gender <input type="checkbox"/> M <input type="checkbox"/> F
	Date of Birth / /	<input type="checkbox"/> Add <input type="checkbox"/> Delete
Dependent Child (Last, First, Middle Initial)	Social Security Number	Gender <input type="checkbox"/> M <input type="checkbox"/> F
	Date of Birth / /	<input type="checkbox"/> Add <input type="checkbox"/> Delete
Dependent Child (Last, First, Middle Initial)	Social Security Number	Gender <input type="checkbox"/> M <input type="checkbox"/> F
	Date of Birth / /	<input type="checkbox"/> Add <input type="checkbox"/> Delete



### 5 Additional dependents...

Dependent Child (Last, First, Middle Initial)	Social Security Number	Gender <input type="checkbox"/> M <input type="checkbox"/> F
	Date of Birth / /	<input type="checkbox"/> Add <input type="checkbox"/> Delete
Dependent Child (Last, First, Middle Initial)	Social Security Number	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: \_\_\_\_\_

### 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
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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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_