6950 NE Campus Way
Hillsboro, OR 97124
www.WillametteDental.com

Dental Enrollment Application and Change of Information Form

You must complete this enrollment form to participate in the dental plan

Willamette Dental of Idaho, Inc.

TYPE OF APPLICATION: ■ New Application ■ Change of Information

☐ COBRA* ☐ 18 Months ☐ 29 Months ☐ 36 Months *Continuation Qualifying Event _______

PLEASE TYPE OR PRINT - PRESS FIRMLY - ALL ITEMS MUST BE COMPLETED

LAST NAME	FIRST NAME	M.	MALE	FEMALE	SOCIAL SECURITY NUMBER	EMPLOYEE ID NUMBER

ADDRESS	HOME PHONE

CITY	STATE	COUNTY	ZIP CODE	WORK PHONE	EFFECTIVE DATE

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

NAME OF EMPLOYER	ADDRESS	CITY	STATE	ZIP CODE

☐ I AM ENROLLING MYSELF ONLY ☐ I AM ENROLLING MYSELF & DEPENDENTS (LIST DEPENDENTS INFORMATION BELOW)

RELATIONSHIP CODES
A - Natural Child C - Step Child
B - Legally Adopted D - Other (Explain)

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

To change enrollment information, please provide the appropriate information below.

☐ Change Address - Complete address section on reason line below.
☐ Add Dependent - Complete dependent section and note reason and effective date on reason line below.
☐ Delete Dependent - Complete dependent section and note reason and effective date on reason line below.
☐ Name Change - Note effective date and old/new names on the reason line below.
☐ Termination ☐ Open Enrollment ________________________

Other Dental Plans

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

NAME OF CARRIER POLICY NUMBER

Application/Authorization/Certification

I hereby apply for coverage through Willamette Dental of Idaho, 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 co-payments, 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 Idaho, Inc.. I authorize any other provider of health services to give Willamette Dental of Idaho, 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 Idaho, 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 Idaho, 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.

SIGNATURE DATE

MONTH DAY YEAR

PLEASE TYPE OR PRINT - PRESS FIRMLY - ALL ITEMS MUST BE COMPLETED

Employer Verification

EMPLOYER/ADDRESS

TELEPHONE | REVIEWED BY

SIGNATURE | TITLE

For Office Use Only

GROUP # | EFFECTIVE DATE

ACCT TYPE | PROVIDER

Waiver Of Group Dental Insurance

LAST NAME | FIRST NAME | M.

NAME OF EMPLOYER

I HEREBY WAIVE THE RIGHT TO GROUP DENTAL INSURANCE OFFERED THROUGH MY EMPLOYER.

☐ EMPLOYEE & DEPENDENTS

☐ DEPENDENTS ONLY

SIGNATURE | DATE