

# 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 (marriage, adoption, birth, loss of other coverage)
  - 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 <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



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## 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
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

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

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

## 2017 OAR BENEFIT ELECTION FORM Willamette Dental

Check box for  
your selection

### **Willamette Dental**



*Stand Alone Voluntary High Option*

♦ No Deductible ♦ No Annual Maximum  
\$10 Office Visit Copay Per Visit-Schedule Plan

**Predictable low copays:**

Fillings: Covered at 100%  
Porcelain-Metal Crown: \$150  
Complete Upper or Lower Denture: \$225  
Bridge: \$150  
Root Canal Therapy: \$85-140  
Routine Extraction: Covered at 100%  
Surgical Extraction: \$80  
Comprehensive Orthodontic Service: \$1,500

Cost for you	You & Spouse	You and Child(ren)	Family
\$ 54.55	\$ 97.40	\$ 109.10	\$ 152.10

*Stand Alone Voluntary Low Option*

♦ No Deductible ♦ No Annual Maximum  
\$15 office Visit Copay Per Visit-Schedule Plan

**Predictable low copays:**

Fillings: Covered at 100%  
Porcelain-Metal Crown: \$300  
Complete Upper or Lower Denture: \$400  
Bridge: \$300  
Root Canal Therapy: \$100-\$190  
Routine Extraction: Covered at 100%  
Surgical Extraction: \$80  
Comprehensive Orthodontic Service: \$2,800

Cost for you	You & Spouse	You and Child(ren)	Family
\$ 35.95	\$ 64.20	\$ 71.90	\$100.25

Monthly Bill Fee – \$3.00 (EFT) \$4.00 (Direct Bill) \*Bill Fee Waived First Month\*Not Included

**Note:** This is a brief summary and does not constitute a contract or guarantee of benefits.

The description above is for illustrative purposes only. Please refer to the Features Summary for a more complete understanding of the benefits and services each carrier provides.

If you should have any questions please contact Julie Petersen at Cypress Benefit Administrators at 866-542-1874 or Johnson Benefit Group at 1-866-656-3232. We are here to help.

Print Name: \_\_\_\_\_

Group Code: OR197

Signature: \_\_\_\_\_

Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Address: \_\_\_\_\_

*MEMBER BENEFITS PLAN C/O Julie Peterson,  
Cypress Benefit Administrators 5560 West Grande Market Drive Appleton WI 54913  
Or FAX to: 866-542-1874*