TRUECARE WASHINGTON ENROLLMENT APPLICATION

Willamette Dental Group

You are eligible for individual coverage under the TrueCare Washington plan if you are a Washington resident and are at least 18 years of age. Your eligible dependents include your spouse or domestic partner, child under age 26, and spouse's or domestic partner's child under age 26. Members may not be enrolled under any other insurance plan issued or offered by Willamette Dental of Washington, Inc. or its affiliates.

To enroll in the TrueCare Washington plan, complete both sides of this application, including your signature on the back. Please mail the completed application and premium payment to the address below.

Willamette Dental of Washington, Inc.
TrueCare Washington
6950 NE Campus Way
Hillsboro, OR 97124

If we receive your application and premium payment between the 1st and 25th of the month, your coverage will be effective on the first day of the following month. If paying by Auto Pay or credit card, application and payment can be submitted by fax or email to 503-952-2679 or tcw@willamettedental.com.

1 Rate Selection (Select Ages for All Enrollees and Calculate Total Monthly Premium)

Age		# of Enrollees		Monthly Rate		Total Premium Rate per Age Band
☐	0 - 25		X	$45.43	=	
☐	26 - 34		X	$49.50	=	
☐	35 - 44		X	$54.87	=	
☐	45 - 54		X	$64.28	=	
☐	55+		X	$75.87	=	
TOTAL MONTHLY PREMIUM DUE FOR ALL ENROLLEES					=	

2 Premium Payment – Please Select Auto Pay or Check

☐ Auto Pay via checking account deduction. Please complete information below - we do not need a voided check.

- Bank Name: _____ Routing Number: _____
- Checking Account Number: _____

☐ Auto Pay via Credit Card: Provide the card information below.

Card Type: ☐ Visa ☐ Mastercard ☐ Discover	Credit Card Number:
Expiration Date:	3-Digit Security Code:
Cardholder's Signature:	

If Auto-Pay is selected, I hereby authorize Willamette Dental of Washington, Inc., to make reoccurring monthly withdrawals from the checking account / credit card listed for the then-current TrueCare Washington premium amount. This authorization will remain in effect until I have provided 5 business days' prior written notice to Willamette Dental of Washington, Inc., and my bank.

☐ Personal check, cashier's check, or money order: Enclose the first month's premium with this application payable to Willamette Dental of Washington, Inc.

3 Applicant Enrollment Information

Self (Last, First, Middle Initial):	Social Security Number (*not required*):		
Requested Effective Date:	Gender:	Date of Birth:	
Mailing Address:	City:	State:	Zip:
Home Phone:	Email Address:		

CONTINUE APPLICATION ON NEXT PAGE...

4 Dependent Enrollment Information

Legal Spouse or Domestic Partner (Last, First, Middle Initial):		
Social Security Number (*not required*):	Gender:	Date of Birth:
Dependent Child (Last, First, Middle Initial):		
Social Security Number (*not required*):	Gender:	Date of Birth:
Dependent Child (Last, First, Middle Initial):		
Social Security Number (*not required*):	Gender:	Date of Birth:
Dependent Child (Last, First, Middle Initial):		
Social Security Number (*not required*):	Gender:	Date of Birth:

5 Producer of Record Information. ***Please note: This section only applies to individuals applying with the help of an insurance agent.*** *Producers are required to have and maintain a Washington producer license and appointment with Willamette Dental of Washington, Inc.*

Producer Name: Kyla Beamon		Agency Name: Same	
Physical Address: 8645 SW Greenswood Ln	City: Tigard	State: OR	Zip: 97224
Phone Number: 503-314-9848	Email Address: WiseEndeavors@comcast.net		

6 Acknowledgments and Signature

- I hereby apply for coverage under the TrueCare Washington policy underwritten by Willamette Dental of Washington, Inc., 6950 NE Campus Way, Hillsboro, OR 97124, for myself and my listed dependents.
- I authorize providers of 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 administration of benefits in fulfillment of obligations imposed on Willamette Dental of Washington, Inc., by state or federal law.
- I understand if the application is declined and coverage is not issued, Willamette Dental of Washington, Inc.'s only obligation will be to return any premium paid. If an incomplete application is received, a letter will be mailed to the applicant requesting the additional information. If the missing information is not received within two weeks, the application will be declined.
- I certify that all information supplied in this application form 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 31 days from the date of change.
- I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
- If I choose to sign this application by typing my name below, I acknowledge and agree that my typewritten signature has the same legal effect as my written signature on this application.

X _____ X _____

Applicant's Signature Date