Multnomah Bar Association
Willamette Dental Enrollment Form

Willamette Dental Group

Email completed form to: scarpentier@aldrichadvisors.com

Please make your selection below: ***Questions call 503-716-9328***

___ Dental Only ___ Dental and Vision (VSP)

1 I'm filling out this application because I am...

If an attorney OSB #_____

- ☐ 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 - Type of qualifying event: _____
    Date of qualifying event: _____
- ☐ 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 OR 133 - Multnomah Bar Assoc.	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 ☐ M ☐ 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 ☐ M ☐ F
	Date of Birth ☐ Husband/Wife ☐ Dom. Part.	☐ Add ☐ Delete
Dependent Child (Last, First, Middle Initial)	Social Security Number	Gender ☐ M ☐ F
	Date of Birth	☐ Add ☐ Delete
Dependent Child (Last, First, Middle Initial)	Social Security Number	Gender ☐ M ☐ F
	Date of Birth	☐ Add ☐ Delete
Dependent Child (Last, First, Middle Initial)	Social Security Number	Gender ☐ M ☐ F
	Date of Birth	☐ Add ☐ Delete

Please continue application on back...

Dental Enrollment Application Continued...

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5 Additional dependents...

Dependent Child(Last, First, Middle Initial)	Social Security Number	Gender ☐ M ☐ F
	Date of Birth	☐ Add ☐ Delete
Dependent Child (Last, First, Middle Initial)	Social Security Number	Gender ☐ M ☐ F
	Date of Birth	☐ Add ☐ Delete

6 Other dental insurance I have...

Are you or any of your dependents 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

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: _____