

# GROUP APPLICATION

DentalandVisionIns.com Wolfpack Insurance Services, Inc.

For use in enrolling in the Small Business Benefit Plan Trust Dental and/or Vision Plans.

Company Name:		Desired Effective Date:
Address:		
City:	State: CALIFORNIA	Zip:
Telephone:	Fax:	
Company Contact:	Contact Email:	
Percentage of Employer Paid Premium: EE: _____ Dep: _____	Type of Group: Corporation _____ Proprietorship _____ Partnership _____	
New Employees will be eligible the first of the month after: 0 _____ 30 _____ 60 _____ 90 _____ 120 _____ 180 _____ or _____ days	Nature of Business:	

<b>Coverage Applied for:</b>	Delta Dental Plan Name:	Include Ortho? Yes No
	Vision Service Plan Name:	Voluntary VSP? Yes No

Prior Dental Carrier: \_\_\_\_\_ Please include a copy of last months invoice

Total number of active eligible Employees:	Total number of ineligible Employees:	Please supply a copy of your latest state wage and earnings report (DE-6).
Total number of enrolling Employees: <small>If less than 5, please supply a copy of your current medical coverage</small>	Number of enrolling COBRA extendees: <small>Please list the termination date of benefits on a separate sheet</small>	

I hereby apply for coverage for the employer of the above firm through the Small Business Benefit Plan Trust. I apply for membership and I agree to the terms and conditions of the trust. I understand that the minimum group size is two or more unrelated employees. The minimum participation is 75% of the eligible employees and the minimum employer contribution is 50% of the employee premium. (participation and contribution minimums do not pertain to the voluntary vision plans) I agree to act as the administrator for COBRA regulations and distribute forms to eligible parties. I certify the information on this form is correct, and understand the coverage does not take effect until the first of the month after the application is accepted by the benefit company. I enclose the first months premium and fees.

Authorized Signature and Title \_\_\_\_\_ Date \_\_\_\_\_  
Please list the employees to be covered on the back side of this form

Premium Calculation				Agent Information
Number of Employees by category	Dental Rate	Vision Rate	Total	Agent and Agency Name
EE Only				Address
EE + Spouse				City State Zip
EE + One Child				Wolfpack Agent Identification Number
EE + Two or More Children				Signature and Date
EE + Family				Phone Number
Administration Fee, \$10 per month (waived for groups of 20+)				Group wallet cards and certificates are mailed to the agent for delivery. Please indicate if you wish us to mail the approval package directly to the group.  _____ Please mail approval package directly to the group
<b>Total Due</b> (check payable to Small Business Benefit Plan Trust)				

Please list only employees and dependents who are to be covered. **Dependent Children between the age of 19 to 25 must be full time students.** Unless noted we will assume all employees and dependents have chosen the same benefits as reflected on the employer side of this application. If you wish to enter this into an Excel spreadsheet and email it to us, please secure the spreadsheet and email it to [marketing@dvinc.com](mailto:marketing@dvinc.com). Please list additional dependents on a separate sheet.

Employee #1 Last Name		First Name		Gender	Born (mm-dd-yyyy)		Social Security Number	
Spouse or Domestic Ptrn Last	First Name		Gender	Born (mm-dd-yy)	Child 1 Last Name		First Name	
Child 2 Last Name	First Name		Gender	Born (mm-dd-yy)	Child 3 Last Name		First Name	
Employee #2 Last Name		First Name		Gender	Born (mm-dd-yyyy)		Social Security Number	
Spouse or Domestic Ptrn Last	First Name		Gender	Born (mm-dd-yy)	Child 1 Last Name		First Name	
Child 2 Last Name	First Name		Gender	Born (mm-dd-yy)	Child 3 Last Name		First Name	
Employee #3 Last Name		First Name		Gender	Born (mm-dd-yyyy)		Social Security Number	
Spouse or Domestic Ptrn Last	First Name		Gender	Born (mm-dd-yy)	Child 1 Last Name		First Name	
Child 2 Last Name	First Name		Gender	Born (mm-dd-yy)	Child 3 Last Name		First Name	
Employee #4 Last Name		First Name		Gender	Born (mm-dd-yyyy)		Social Security Number	
Spouse or Domestic Ptrn Last	First Name		Gender	Born (mm-dd-yy)	Child 1 Last Name		First Name	
Child 2 Last Name	First Name		Gender	Born (mm-dd-yy)	Child 3 Last Name		First Name	
Employee #5 Last Name		First Name		Gender	Born (mm-dd-yyyy)		Social Security Number	
Spouse or Domestic Ptrn Last	First Name		Gender	Born (mm-dd-yy)	Child 1 Last Name		First Name	
Child 2 Last Name	First Name		Gender	Born (mm-dd-yy)	Child 3 Last Name		First Name	
Employee #6 Last Name		First Name		Gender	Born (mm-dd-yyyy)		Social Security Number	
Spouse or Domestic Ptrn Last	First Name		Gender	Born (mm-dd-yy)	Child 1 Last Name		First Name	
Child 2 Last Name	First Name		Gender	Born (mm-dd-yy)	Child 3 Last Name		First Name	
Employee #7 Last Name		First Name		Gender	Born (mm-dd-yyyy)		Social Security Number	
Spouse or Domestic Ptrn Last	First Name		Gender	Born (mm-dd-yy)	Child 1 Last Name		First Name	
Child 2 Last Name	First Name		Gender	Born (mm-dd-yy)	Child 3 Last Name		First Name	
Employee #8 Last Name		First Name		Gender	Born (mm-dd-yyyy)		Social Security Number	
Spouse or Domestic Ptrn Last	First Name		Gender	Born (mm-dd-yy)	Child 1 Last Name		First Name	
Child 2 Last Name	First Name		Gender	Born (mm-dd-yy)	Child 3 Last Name		First Name	
Employee #9 Last Name		First Name		Gender	Born (mm-dd-yyyy)		Social Security Number	
Spouse or Domestic Ptrn Last	First Name		Gender	Born (mm-dd-yy)	Child 1 Last Name		First Name	
Child 2 Last Name	First Name		Gender	Born (mm-dd-yy)	Child 3 Last Name		First Name	
Employee #10 Last Name		First Name		Gender	Born (mm-dd-yyyy)		Social Security Number	
Spouse or Domestic Ptrn Last	First Name		Gender	Born (mm-dd-yy)	Child 1 Last Name		First Name	
Child 2 Last Name	First Name		Gender	Born (mm-dd-yy)	Child 3 Last Name		First Name	