DeltaCare List Bill and/or Voluntary Vision Plan Application

Company Name:		Desired Effective Date:
Address:		
City:	State: CALIFORNIA	Zip:
Telephone:		
Company Contact:	Contact Email:	

Coverage Applied for: If more than two plans are offered, please indicate which plan a member selected on a separate sheet.	DeltaCare Dental Plan List Bill
	Optional Voluntary Vision Service Plan Name:

Premium Calculation

Number of Employees by category		DeltaCare Rate	Vol Vision Rate	Total
EE Only		$34.20		
EE + Spouse		$60.70		
EE + One Child		$60.70		
EE + Two or More Ch		$89.10		
EE + Family		$89.10		
Administration Fee, $5 per month				
Total Due				

Agent Information

Agent and Agency Name
Address
City State Zip
Wolfpack Agent Identification Number
Signature and Date
Phone Number

Please continue on Page 2

Administration by: Wolfpack Insurance Services, Inc. License # 0814789

Upload completed forms on www.DentalandVisionIns.com
Go to 'Information for Agents'

800-296-0192 PO Box 156 Belmont CA 94002

Email receipt of monthly invoices. We will email your regular premium invoice to you. All other notices will be mailed to your mailing address.

Email the invoices to:_____

cc:_____

Set up Auto Pay from your checking or savings account.

By selecting this option, I (we) hereby authorize Wolfpack Insurance Services Inc. to charge the applicable monthly dues to the account designated below. I understand that coverage will only become and remain effective if there are sufficient funds at the time of the deduction. This authority to deduct funds from my account is to remain in full force and effect until I notify Wolfpack Insurance Services Inc. in writing 30 days prior to termination. (My bank is authorized to make corrections if any should be necessary.) Automatic draft failures (insufficient funds, bank account no longer valid) are subject to a $15.00 fee. Funds are drafted on the 15th of the month prior to the month of coverage. We will send an invoice to about two weeks before the draft occurs giving you the amount to be drafted. Upon Cancellation we will draft any outstanding premium due.

◯ Yes, Please set up an automatic draft of the premium.

◯ No, I will send a monthly check. Groups that do not select Auto Pay will be subject to a monthly administration fee.

Bank Name: _____

Type of Account ◯ Checking or ◯ Savings

This is a ◯ Business/Company Account; or an ◯ Individual Account.

Please verify the account and routing number with your bank if you have any questions.

ABA Routing number (First nine digit number on left hand bottom of your check): _____
(Please call your bank if you have questions on this number.)

Account Number (Second series of numbers on the bottom of the check): _____

Initial premium

◯ Please draft the initial premium and fees from the above account.

◯ Check for initial premium is enclosed.

I hereby apply for coverage for the employer list bill 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 agree to act as the administrator for Voluntary List Bill plan 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. DeltaCare List Bill applications must be received by the 15th of the month prior to the requested effective date.

Signature: _____ Title: _____ Date:_____

Please have each enrolling member complete this application

DELTA CARE APPLICATION, Employer List Bill

This is a dental HMO Program.
To search for a DeltaCare provider, please go to www.deltadentalins.com/individuals/find-a-dentist.html.
As an enrollee in the DeltaCare program, you must select one office for your entire family's needs.

Please indicate the number of the DeltaCare office you have chosen: #_____

Provider Name _____

Employer list bill

Employer Name:_____

Enrollee Social Security Number:_____ Enrollee must be a California Resident

	First Name	Last Name	Male or Female	Date of Birth
Enrollee				
Spouse				
Child				
Child				
Child				
Child				

Employee Address: _____

City: _____ CA Zip Code: _____

I hereby understand and acknowledge that I am enrolling in the Wolfpack Insurance Services Trust group for DeltaCare coverage under group 01675, plan 11B. Benefit and plan information was reviewed from the DentalandVisionIns.com web site, Family Plan Section. I agree to the terms and conditions of the plan.

We will send you a wallet card for your use as confirmation that you are enrolled.
The minimum enrollment period is 12 months. Should you voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

Premium rates renew January 1st of each year and I understand that the group list bill client will be sent a renewal notice to the last known address on Wolfpack Insurance Services systems. I understand that I must utilize by assigned DeltaCare provider to receive benefits. This authorization is valid for the duration of coverage.

Signature of enrollee _____ Date _____

Note: The enrollment information must be received at the latest by the 15th of the month for coverage to begin the 1st of the following month. Incomplete, inaccurate information will cause a delay in your enrollment into the program.

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