GROUP APPLICATION

www.DentalandVisionIns.com Wolfpack Insurance Services, Inc. 800-296-0192

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:		
Company Contact:	Contact Email:	
Percentage of Employer Paid Premium: EE:_____ Dep:_____	Nature of Business:	
New Employees will be eligible the first of the month after: 0 ◯ 30 ◯ 60 ◯ 90 ◯ 120 ◯ 180 ◯ or _____ days		

Coverage Applied for: If more than two plans are offered, please indicate which plan a member selected on the list of members starting on page 3.	Delta Dental Plan Name:	D&P Maximum Waiver? Yes ◯ No ◯ Include Ortho? Yes ◯ No ◯
	Vision Service Plan Name:	Voluntary VSP? Yes No

Please indicate which COBRA regulations your group is subject to for the current year: ◯ CAL COBRA or ◯ Federal COBRA.

Total number of active eligible Employees:	Total number of ineligible Employees:	Please supply a copy of the latest payroll report so that we can check participation.
Total number of enrolling Employees:	Number of enrolling COBRA members: Please list the termination date of benefits on a separate sheet	

Premium Calculation

Number of Employees by category		Dental Rate	Vision Rate	Total
	EE Only			
	EE + Spouse			
	EE + One Child			
	EE + Two or More Children			
	EE + Family			
Administration Fee, $10 per month (See page 2)				
Total Due				

Agent Information

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

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

Please continue on Page 2

Trust Group Application, Continued. Company Name :_____

Groups that enroll in Email receipt of invoice and Auto Pay will have the $10.00 monthly administration fee eliminated. This fee is waived for groups of 20 or more.

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:_____

◯ Please mail the invoices through the US Postal Service.

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 my 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 25th 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: _____

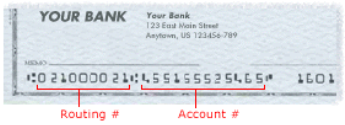
Type of Account ◯ Checking or ◯ Savings

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 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 I understand the coverage does not take effect until the first of the month after the application is accepted by the benefit company.

Signature: _____ Title: _____ Date:_____

Company Name:_____Please list only employees and dependents who are to be covered. Unmarried dependent children are eligible until the end of the month in which they attain the age of 26. Unless noted we will assume all employees and dependents have chosen the same benefits as reflected on the employer side of this application

Employee #1 First Name	Last Name			Gender	Born (mm-dd-yyyy)	Social Security Number	
Address				City		State	Zip
Spouse or Domestic Ptnr First Name	Last Name	Gender	Born (mm-dd-yy)	Child 1 First Name	Last Name	Gender	Born (mm-dd-yy)
Child 2 First Name	Last Name	Gender	Born (mm-dd-yy)	Child 3 First Name	Last Name	Gender	Born (mm-dd-yy)
EE1: Dental Plan				Vision Plan:			
Employee #2 First Name	Last Name			Gender	Born (mm-dd-yyyy)	Social Security Number	
Address				City		State	Zip
Spouse or Domestic Ptnr First Name	Last Name	Gender	Born (mm-dd-yy)	Child 1 First Name	Last Name	Gender	Born (mm-dd-yy)
Child 2 First Name	Last Name	Gender	Born (mm-dd-yy)	Child 3 First Name	Last Name	Gender	Born (mm-dd-yy)
EE2: Dental Plan				Vision Plan:			
Employee #3 First Name	Last Name			Gender	Born (mm-dd-yyyy)	Social Security Number	
Address				City		State	Zip
Spouse or Domestic Ptnr First Name	Last Name	Gender	Born (mm-dd-yy)	Child 1 First Name	Last Name	Gender	Born (mm-dd-yy)
Child 2 First Name	Last Name	Gender	Born (mm-dd-yy)	Child 3 First Name	Last Name	Gender	Born (mm-dd-yy)
EE3: Dental Plan				Vision Plan:			
Employee #4 First Name	Last Name			Gender	Born (mm-dd-yyyy)	Social Security Number	
Address				City		State	Zip
Spouse or Domestic Ptnr First Name	Last Name	Gender	Born (mm-dd-yy)	Child 1 First Name	Last Name	Gender	Born (mm-dd-yy)
Child 2 First Name	Last Name	Gender	Born (mm-dd-yy)	Child 3 First Name	Last Name	Gender	Born (mm-dd-yy)
EE4: Dental Plan				Vision Plan:			
Employee #5 First Name	Last Name			Gender	Born (mm-dd-yyyy)	Social Security Number	
Address				City		State	Zip
Spouse or Domestic Ptnr First Name	Last Name	Gender	Born (mm-dd-yy)	Child 1 First Name	Last Name	Gender	Born (mm-dd-yy)
Child 2 First Name	Last Name	Gender	Born (mm-dd-yy)	Child 3 First Name	Last Name	Gender	Born (mm-dd-yy)
EE5: Dental Plan				Vision Plan:			

Employee #6 First Name	Last Name	Gender	Born (mm-dd-yyyy)	Social Security Number
Address		City	State	Zip

Spouse or Domestic Ptnr First Name	Last Name	Gender	Born (mm-dd-yy)	Child 1 First Name	Last Name	Gender	Born (mm-dd-yy)
Child 2 First Name	Last Name	Gender	Born (mm-dd-yy)	Child 3 First Name	Last Name	Gender	Born (mm-dd-yy)

EE6: Dental Plan | Vision Plan:

Employee #7 First Name	Last Name	Gender	Born (mm-dd-yyyy)	Social Security Number
Address		City	State	Zip

Spouse or Domestic Ptnr First Name	Last Name	Gender	Born (mm-dd-yy)	Child 1 First Name	Last Name	Gender	Born (mm-dd-yy)
Child 2 First Name	Last Name	Gender	Born (mm-dd-yy)	Child 3 First Name	Last Name	Gender	Born (mm-dd-yy)

EE7: Dental Plan | Vision Plan:

Employee #8 First Name	Last Name	Gender	Born (mm-dd-yyyy)	Social Security Number
Address		City	State	Zip

Spouse or Domestic Ptnr First Name	Last Name	Gender	Born (mm-dd-yy)	Child 1 First Name	Last Name	Gender	Born (mm-dd-yy)
Child 2 First Name	Last Name	Gender	Born (mm-dd-yy)	Child 3 First Name	Last Name	Gender	Born (mm-dd-yy)

EE8: Dental Plan | Vision Plan:

Employee #9 First Name	Last Name	Gender	Born (mm-dd-yyyy)	Social Security Number
Address		City	State	Zip

Spouse or Domestic Ptnr First Name	Last Name	Gender	Born (mm-dd-yy)	Child 1 First Name	Last Name	Gender	Born (mm-dd-yy)
Child 2 First Name	Last Name	Gender	Born (mm-dd-yy)	Child 3 First Name	Last Name	Gender	Born (mm-dd-yy)

EE9: Dental Plan | Vision Plan:

Employee #10 First Name	Last Name	Gender	Born (mm-dd-yyyy)	Social Security Number
Address		City	State	Zip

Spouse or Domestic Ptnr First Name	Last Name	Gender	Born (mm-dd-yy)	Child 1 First Name	Last Name	Gender	Born (mm-dd-yy)
Child 2 First Name	Last Name	Gender	Born (mm-dd-yy)	Child 3 First Name	Last Name	Gender	Born (mm-dd-yy)

EE10: Dental Plan | Vision Plan:

Employee #11 First Name	Last Name	Gender	Born (mm-dd-yyyy)	Social Security Number
Address		City	State	Zip

Spouse or Domestic Ptnr First Name	Last Name	Gender	Born (mm-dd-yy)	Child 1 First Name	Last Name	Gender	Born (mm-dd-yy)
Child 2 First Name	Last Name	Gender	Born (mm-dd-yy)	Child 3 First Name	Last Name	Gender	Born (mm-dd-yy)

EE11: Dental Plan	Vision Plan:

Employee #12 First Name	Last Name	Gender	Born (mm-dd-yyyy)	Social Security Number
Address		City	State	Zip

Spouse or Domestic Ptnr First Name	Last Name	Gender	Born (mm-dd-yy)	Child 1 First Name	Last Name	Gender	Born (mm-dd-yy)
Child 2 First Name	Last Name	Gender	Born (mm-dd-yy)	Child 3 First Name	Last Name	Gender	Born (mm-dd-yy)

EE12: Dental Plan	Vision Plan:

Employee #13 First Name	Last Name	Gender	Born (mm-dd-yyyy)	Social Security Number
Address		City	State	Zip

Spouse or Domestic Ptnr First Name	Last Name	Gender	Born (mm-dd-yy)	Child 1 First Name	Last Name	Gender	Born (mm-dd-yy)
Child 2 First Name	Last Name	Gender	Born (mm-dd-yy)	Child 3 First Name	Last Name	Gender	Born (mm-dd-yy)

EE13: Dental Plan	Vision Plan:

Employee #14 First Name	Last Name	Gender	Born (mm-dd-yyyy)	Social Security Number
Address		City	State	Zip

Spouse or Domestic Ptnr First Name	Last Name	Gender	Born (mm-dd-yy)	Child 1 First Name	Last Name	Gender	Born (mm-dd-yy)
Child 2 First Name	Last Name	Gender	Born (mm-dd-yy)	Child 3 First Name	Last Name	Gender	Born (mm-dd-yy)

EE14: Dental Plan	Vision Plan:

Employee #15 First Name	Last Name	Gender	Born (mm-dd-yyyy)	Social Security Number
Address		City	State	Zip

Spouse or Domestic Ptnr First Name	Last Name	Gender	Born (mm-dd-yy)	Child 1 First Name	Last Name	Gender	Born (mm-dd-yy)
Child 2 First Name	Last Name	Gender	Born (mm-dd-yy)	Child 3 First Name	Last Name	Gender	Born (mm-dd-yy)

EE15: Dental Plan	Vision Plan:

Employee #16 First Name	Last Name			Gender	Born (mm-dd-yyyy)	Social Security Number		
Address				City			State	Zip
Spouse or Domestic Ptnr First Name	Last Name	Gender	Born (mm-dd-yy)	Child 1 First Name	Last Name		Gender	Born (mm-dd-yy)
Child 2 First Name	Last Name	Gender	Born (mm-dd-yy)	Child 3 First Name	Last Name		Gender	Born (mm-dd-yy)
EE16: Dental Plan				Vision Plan:				
Employee #17 First Name	Last Name			Gender	Born (mm-dd-yyyy)	Social Security Number		
Address				City			State	Zip
Spouse or Domestic Ptnr First Name	Last Name	Gender	Born (mm-dd-yy)	Child 1 First Name	Last Name		Gender	Born (mm-dd-yy)
Child 2 First Name	Last Name	Gender	Born (mm-dd-yy)	Child 3 First Name	Last Name		Gender	Born (mm-dd-yy)
EE17: Dental Plan				Vision Plan:				
Employee #18 First Name	Last Name			Gender	Born (mm-dd-yyyy)	Social Security Number		
Address				City			State	Zip
Spouse or Domestic Ptnr First Name	Last Name	Gender	Born (mm-dd-yy)	Child 1 First Name	Last Name		Gender	Born (mm-dd-yy)
Child 2 First Name	Last Name	Gender	Born (mm-dd-yy)	Child 3 First Name	Last Name		Gender	Born (mm-dd-yy)
EE18: Dental Plan				Vision Plan:				
Employee #19 First Name	Last Name			Gender	Born (mm-dd-yyyy)	Social Security Number		
Address				City			State	Zip
Spouse or Domestic Ptnr First Name	Last Name	Gender	Born (mm-dd-yy)	Child 1 First Name	Last Name		Gender	Born (mm-dd-yy)
Child 2 First Name	Last Name	Gender	Born (mm-dd-yy)	Child 3 First Name	Last Name		Gender	Born (mm-dd-yy)
EE19: Dental Plan				Vision Plan:				
Employee #20 First Name	Last Name			Gender	Born (mm-dd-yyyy)	Social Security Number		
Address				City			State	Zip
Spouse or Domestic Ptnr First Name	Last Name	Gender	Born (mm-dd-yy)	Child 1 First Name	Last Name		Gender	Born (mm-dd-yy)
Child 2 First Name	Last Name	Gender	Born (mm-dd-yy)	Child 3 First Name	Last Name		Gender	Born (mm-dd-yy)
EE20: Dental Plan				Vision Plan:				