DELTA DENTAL ENROLLMENT INSTRUCTIONS

To apply for dental benefits, complete the application by following these four simple steps.

- **Step 1** – Complete contact information.
- **Step 2** – Calculate your total monthly premium using the worksheet included on page 4.
- **Step 3** – Complete the Enrollment Form for each individual applying for coverage. Select the dental plan, fill out all employee/individual information and make sure to include any dependent information for the covered individual.
- **Step 4** - Return the application, enrollment forms and any waivers, along with your first payment to *Hutchison Financial Group*. You will receive a confirmation letter upon enrollment. If you are enrolling in WHA and VSP as well, please combine all premiums on one check. Please note that we must receive your application for enrollment, along with payment no later than the 10th of the current month in which you want your benefits to begin.

We look forward to working with you. Please feel free to contact us by phone at (916) 944-1707 or by email at caps@capsplans.com if you have any questions or would like additional information.

STEP 1 – CONTACT INFORMATION (please print)

Name: _____

Company: _____

Billing Contact: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Phone/ Fax: _____

E-mail: _____

*Total # of Enrollees: _____

STEP 2 – MONTHLY PREMIUM CALCULATION WORKSHEET

(See Pages 1-2 for Rates)

DENTAL COVERAGE

DeltaPremier Voluntary		
Coverage Type	*# of Employees*	*Monthly Rate*
Employee Only		$ 38.00
+ 1 Dependant		$ 64.00
Family		$ 97.00

DeltaCare PMI Voluntary		
Coverage Type	*# of Employees*	*Monthly Rate*
Employee Only		$ 34.00
+ 1 Dependant		$ 55.00
Family		$ 77.00

TOTAL PREMIUM CALCULATION

Coverage	Total
DeltaPremier Voluntary	$
DeltaCare PMI Voluntary	$
Total Amount Due	**$**

This section must be completed.

STEP 3 – ENROLLMENT FORM

(Please complete one form for each employee.)

Name: _____

Social Security #: _____ Date of Birth: _____

Home Address: _____

City, State, Zip: _____

Dependent: _____ Relationship: _____

Social Security #: _____ Date of Birth: _____

Dependent: _____ Relationship: _____

Social Security #: _____ Date of Birth: _____

Dependent: _____ Relationship: _____

Social Security #: _____ Date of Birth: _____

Dependent: _____ Relationship: _____

Social Security #: _____ Date of Birth: _____

COVERAGE SELECTION: **Requested Coverage Effective Date: _____**

Employee/Dependent Coverage	*DeltaPremier	*DeltaCare/PMI
Employee Only	☐	☐
Employee + One	☐	☐
Employee + Family	☐	☐

*Rates are effective through 10/31/2016

IMPORTANT NOTE FOR DELTACARE/PMI ENROLLEES:

If you do not specify a dentist of your choice, a dentist will be automatically selected for you. For a list of DeltaCare Dentists please visit www.deltadentalins.com/pmi.

Dentist Name _____ Dentist # _____

ENROLLEE AGREEMENT

I certify that all information I have given is correct. My signature hereon signifies enrollment in the dental plan as indicated above. I understand that my coverage will not be effective unless this application is accepted by Capitol Association Plans and until the date indicated above, which must be on the first day of month in which I wish to receive coverage. I also understand that my application must be received by the 10th of the current month in which I wish to receive coverage, otherwise, my coverage will commence on the first of the following month. I understand that my membership is for a minimum of the remainder of the plan year (November 1st – October 31st). I understand that coverage renews automatically until canceled by submitting a "Change Request Form" to Capitol Association Plans (please contact CAPS for this form at 916-944-1707).

Enrollee Signature: _____ Date: _____

PAYMENT AND BILLING INFORMATION

-For your initial enrollment, please mail all checks and enrollment forms to:

Hutchison Financial Group
5 Sierragate Plaza, Suite 340
Roseville, CA 95678

- Check/Money Order:

  Make Checks Payable to Capitol Association Plans
  Mail Payments to P.O. Box 3040, Fair Oaks, CA 95628-9403
  (Submit payments to this address after initial enrollment has been processed)