# 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 | | $ 29.00 |
| + 1 Dependant | | $ 50.00 |
| Family | | $ 75.00 |

| DeltaCare PMI Voluntary | | |
|---|---|---|
| *Coverage Type* | *# of Employees* | *Monthly Rate* |
| Employee Only | | $ 27.00 |
| + 1 Dependant | | $ 45.00 |
| Family | | $ 62.00 |

**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 10/31/2010

***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)