DentalandVisionIns.com

Dental and/or Vision Addition and Deletion Forms – 2 pages Revised 04-17-2014

You can also submit additions, deletions, and changes from our web site. Go to www.DVIns.com and click on 'Manage Your Account'.

Addition or Member Address Change

Client I.D.: ____

Group Name: ____

Add New Member - Date Hired: ______-______-______
Add Dependents to an existing member
Address Change for a Member
Other ____

Please indicate the desired month coverage should take effect: ______________________
Coverage is only effective on the first of the month.

Employee Information

Social Security #: ______________________________
We will assign an alternative identification number to be used with the provider. The alternative identification number will show on your wallet card. The Social Security number will not show on any of our communications.

First Name: ____________________________ Last Name: _______________________________

Birth Date: MM\DD\YYYY _________________________ Gender: Male Female

Address: ____

City: _______________________________________ State: _______ Zip: ______________
Send Issuing Materials to: Group address Member address

Dependent Information (Please list only the dependents you wish to have enrolled)

Last Name (if different)	First	Gender (M/F)	Relationship	Birth Date

Please indicate the coverage applied for: ____

A note about waiting periods for Dental Plans:
For groups of less than 10 enrolled members Delta Dental applies a 12 month waiting period for Major Services. If your group has the optional Orthodontic Benefit a 12 month waiting period also applies to the Orthodontic services.
We can waive these waiting periods with proof of continuous prior group coverage for the past 12 months. For the Orthodontic benefit waiting period to be waived the proof must also show that Orthodontia was a covered benefit with the prior coverage. Proof can consist of a Credible Coverage form from the prior carrier or an internet screen print-out from the prior carrier showing the dates of coverage and benefits.
The proof must be submitted with this enrollment form and cannot be submitted at a later date.

I certify the above is correct and understand the coverage does not take effect until the after the application is accepted by the benefit company.

Employee's Signature _______________________________ Date _____-_____-_____

Please keep a copy for your records and then send the application to:
Wolfpack Insurance Services, P. O. Box 156, Belmont CA 94002 Lic # 0814789 Fax: 650-591-4022
Fax: 650-591-4022

Deletion or Delete Dependents

Client I.D.: ____

Group Name: ____

Delete Member and all dependents
Delete listed dependents only

Coverage should stop at the end of which month: ___________________
Coverage is always terminated at the end of a month. Credit can only be given for the current month.

Employee Information
Identification # : __________________________ Name: ____

Dependent Information – List dependents only if you are just deleting dependents and keeping the employee coverage active.
Only list dependents to be deleted

Last Name (if different)	First	Relationship	Birth Date

Important information about COBRA

All group are subject to COBRA regulations. Federal COBRA is for groups that had 20 or more employees on more than 50 percent of its typical business days in the previous calendar year. Both full and part-time employees are counted to determine whether a plan is subject to COBRA. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full-time. Groups of 2 to 19 are subject to Cal-COBRA regulations. Please go to www.dvins.com, 'Manage Your Account' to report which COBRA regulations apply to your group. This may change every calendar year.

Cal-COBRA groups will need to give us the members address with the reason for termination of coverage; we will generate the Cal-COBRA election form and invoice the member directly for the coverage.

Cal-COBRA Home Address: ____

____ Zip______________

Please indicate the reason for this termination of coverage.

Voluntary termination of employment	Social Security Disabled	Death of Subscriber
Involuntary termination of employment	Legal Separation or Divorce	Active employee dropping coverage
Reduction of work hours	Dependent ceasing to be eligible	

Federal COBRA groups will need to issue a COBRA form with the termination of coverage. Please visit www.dvins.com, click on 'Manage Your Account', then Print Applications, Forms, Plan Descriptions & Certificates' to get the Federal COBRA form. Members who extend coverage under Federal COBRA will be invoiced with the group and the individual premium collection is done by the group.

I certify the above is correct.

Employer's Signature _________________________________ Date _______________

Please keep a copy for your records and then send the form to:

Wolfpack Insurance Services, P. O. Box 156, Belmont CA 94002 Lic # 0814789

Fax: 650-591-4022