Please print this form WOLFPACK DELTA CARE APPLICATION, Employer List Bill

Mail to: Wolfpack Insurance Services, Inc. 800-296-0192 CA License # 0814789
Small Business Benefit Plan Trust Plan
P. O. Box 156 Belmont CA 94002

Agent Information:
Agent Name:
Agent Address:
Agent Phone #

This is a dental HMO Program. You and your family must receive all treatment from the DeltaCare dental office you select.

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

Provider Name _____

Employer list bill

Employer Name:_____ Client ID: _____

Employer address _____ City_____
State: California Zip Code :_____

Employer Contact: _____ Employer Phone Number: _____

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 copy of the Evidence of Coverage for Plan 11B along with 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 I will be sent a renewal notice to the last known address on Wolfpack Insurance Services systems. I hereby authorize my medical or dental care institution or professional to release to a representative of DeltaCare, any personal, privileged or medical records information including, but not limited to, my patient records, charts, x-rays, diagnosis histories, billing records, clinical abstracts, or copies of consultations. The information authorized herein may be used for determination of benefits, quality assessment, utilization review, grievance resolution. or investigation or compliance with the PMI provider agreements or local, state or federal laws. 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.