

Please print this form DELTA CARE APPLICATION

Mail to: Gordon Paul
 1368 W. Herndon Avenue, Suite 101
 Fresno CA 93711

Agent Name: Gordon Paul
 Agent Address: 1368 W. Herndon Avenue, Suite 101, Fresno, CA 93711
 Agent Phone # 888-492-7245

DeltaCare from PMI Dental Health Plan

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 _____

Rates for Calendar year 2008:		
Enrollment type	Monthly (Automatic Deduction)	Quarterly (Payment By Check)
One Person	\$30.30	\$90.90
Two Persons	\$53.50	\$157.50
Three Persons or more	\$76.80	\$235.800

Select your Payment Option:

Monthly (Automatic) Please include a check for the first months premium plus a \$5.00 enrollment fee with this application

Quarterly (Payment by Check), Please include a check for the first Quarters premium payment and a \$5.00 enrollment fee and a \$3.00 billing fee.

Enrollee Mailing Address City State Zip

Enrollee Social Security Number:

Phone Number:

	First Name	Last Name	Gender	Date of Birth
Enrollee				
Spouse				
Child				
Child				
Child				
Child				

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 prior to enrolling in the plan. 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 PMI, 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.

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 or inaccurate information will cause a delay in your enrollment into the program.

Automatic Payment Authorization – Complete if you are requesting Monthly Premium Payment.

I (we) hereby authorize Wolfpack Insurance Services, Inc to charge monthly dues for dental coverage 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. I understand the deduction occurs on or around the 15th of the month prior to the month of coverage.

Checking Account OR Savings Account (Please enclose a voided check or preprinted deposit slip from the account checked)

Bank or Savings and Loan Name: _____

Branch: _____ Branch Telephone Number: _____

Bank Routing Number: _____ Account Number: _____

Please Verify your account information with your bank.

Signature of enrollee _____ Date _____