Capitol Association Plans
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CAPCA Employer Dental & Vision Enrollment Form

Thank you for your interest in the **California Association of Pest Control Advisors** (CAPCA) dental and vision programs. This document contains the necessary enrollment documents to get you started. Should you have any questions, please contact our office by phone at (916) 944-1707, email us at caps@capsplans.com or browse CAPCA's insurance website at www.capsplans.com/capca/.

DENTAL PLANS:

CAPCA's dental plans offer a variety of choices designed to meet the needs of employers wanting to offer quality dental care to their employees.

A. CAPCA MEMBER EMPLOYERS: Delta Dental Non-Voluntary (Employer Paid) Program

Under this group plan, employers must contribute a minimum of 50% to the employee's premium, but are not required to contribute for dependant coverage. Also, all employees who work over 32 hours are required to be covered unless they sign a waiver declining coverage. (Employees declining coverage will not be eligible to enroll at a later date unless they can show proof of loss of prior coverage. Employees are eligible on the first day of the month following six full months of employment; During the initial plan enrollment, Employers may choose to waive the waiting period for enrollees.)

CAPCA dental benefits are provided by Delta Dental, California's largest dental benefits carrier. The DeltaPreferred Option (DPO) and each of the DeltaPremier plans allow you to visit any licensed dentist, although you receive advantages, such as in-network contracted rates when choosing a network dentist. To find a Delta Dental dentist near you, please visit www.deltadentalins.com. See summary of plan benefits listed below:

Delta Dental Benefits	Delta Dental PPO Plan A w/ Ortho (3084-1000)	DeltaPremier Option 1 (3084-0077)	DeltaPremier Option 2 (3084-0047)
Provider Network	In Network/DPO Dentists 11,000+ Out of Network/ Any Dentist 22,000+	Delta Premier Network 22,000+	Delta Premier Network 22,000+
Annual Deductible	$25 Individual $50 Family	$25 Individual $50 Family	$25 Individual $75 Family
Deductible Waived on Diagnostic & Preventative	In Network: Yes Out of Network: No	Yes	No
Diagnostic & Preventative	In Network: Plan Pays 100% Out of Network: Pays 80%	Plan Pays 100%	Plan Pays 80%
Basic (Fillings, Tooth Extraction, etc.)	In Network: Plan Pays 80% Out of Network: Pays 80%	Plan Pays 80%	Plan Pays 80%
Crowns & Cast Restorations	In Network: Plan Pays 80% Out of Network: Pays 50%	Plan Pays 80%	Plan Pays 50%
Prosthodontics	In Network: Plan Pays 50% Out of Network: Plan Pays 50%	Plan Pays 50%	Plan Pays 50%
Child Orthodontics	Plan Pays 50% (up to lifetime max)	N/A	N/A
Maximum Annual Benefit	$1,500	$1,000	$1,000
Orthodontic Lifetime Maximum Benefit	$1,500	N/A	N/A

Delta Dental Non-Voluntary (Employer Paid) Plan Monthly Rate Comparison:
(Rates are effective through 4/30/09)

	Delta Dental PPO Plan A w/Ortho	DeltaPremier Option 1	DeltaPremier Option 2
Employee Only	$ 48.82	$ 50.18	$ 40.49
Employee + One	$ 89.83	$ 92.38	$ 73.24
Employee + Family	$ 166.34	$ 163.11	$ 121.92

B. CAPCA MEMBER EMPLOYERS & INDIVIDUALS: Delta Dental Voluntary Program

Voluntary programs allow individual members and their employees (part-time and full-time) a choice to participate in dental benefits on a voluntary basis. ***These programs provide no waiting periods to receive benefits.*** There are two coverage options in the voluntary program, DeltaPremier and DeltaCare.

CAPCA dental benefits are provided by Delta Dental, California's largest dental benefits carrier. To find a Delta Dental dentist near you, please visit www.deltadentalins.com. See summary of plan benefits listed below:

Dental Coverage	DeltaPremier	DeltaCare
Provider Network	22,000+	1500+ Offices
Deductible	$50 Individual $150 Family	None
Complete series x-ray including bitewings	Plan Pays $45	Plan Pays 100%
Cleaning – adult or child	Plan Pays $36	Plan Pays 100%
Silver Filling – One Surface	Plan Pays $35	Member Pays $2
Single Tooth Extraction	Plan Pays $39	Member Pays $5
Root Canal Therapy, Front Tooth	Plan Pays $193	Member Pays $50
Crown – porcelain (with non-precious metal)	Plan Pays $163	Member Pays $100
Complete denture, upper	Plan Pays $240	Member Pays $125
Orthodontic	Not Covered	Requires Co-Payment $1,600 for Child + $350 $1,800 for Adult
Maximum Annual Benefit	$1,000	No Maximum, Except for Accidental Injury

Delta Dental Voluntary Plan Monthly Rate Comparison:
(Rates are effective through 10/31/08)

Employee/Dependent Coverage	*DeltaPremier	*DeltaCare
Employee Only	$ 29.00	$ 25.00
Employee + One	$ 50.00	$ 43.00
Employee + Family	$ 75.00	$ 58.00

VISION PLANS:

A. CAPCA MEMBER EMPLOYERS: VSP Non-Voluntary (Employer Paid) Program

CAPCA's vision program offers you and your full-time employees high quality eye care services that include an exam and lenses or contacts every 12 months and frames every 24 months, with no waiting periods for benefits. As with CAPCA dental plans, employers must contribute a minimum of 50% to the employee's premium, but are not required to contribute for dependent coverage. All employees who work over 32 hours are required to be covered unless they sign a waiver declining coverage and employees declining vision coverage upon their eligibility will not be eligible to enroll at a later date unless they can show proof of loss of prior coverage.

CAPCA vision benefits are provided by Vision Service Plan (VSP), the Nation's largest provider of exceptional eye care coverage. VSP offers the most extensive national doctor network of independent, private practitioners, for more information, or to find a provider near you, please visit www.vsp.com. See below for a summary of plan benefits.

VSP Non-Voluntary (Employer Paid) Plan Benefits:

Vision Coverage	Vision Service Plan
Exam	Every 12 Months
Lenses** (Single vision, lined bifocal, and lined trifocal lenses)	Every 12 Months
Frames** (Frame of your choice covered up to $105. Plus, %20 off any out-of pocket costs)	Every 24 Months
-- OR -- Contacts	Every 12 Months

**Subject to a $20 co pay

VSP Non-Voluntary (Employer Paid) Plan Monthly Rate Comparison:
(Rates are effective through 04/30/08)

Employee/Dependent Coverage	Vision Service Plan
Employee Only	$ 11.49
Employee + One Dependent	$ 17.84
Employee + Family	$ 28.31

B. CAPCA MEMBER EMPLOYERS & INDIVIDUALS: VSP Voluntary Program

Voluntary programs allow individual members and their employees (part-time and full-time) a choice to participate in vision benefits on a voluntary basis. ***These programs provide no waiting periods to receive benefits.*** CAPCA's vision program offers you and your employees high quality eye care services that include an exam and lenses or contacts every 12 months and frames every 24 months, with no waiting periods for benefits.

CAPCA vision benefits are provided by Vision Service Plan (VSP), the Nation's largest provider of exceptional eye care coverage. VSP offers the most extensive national doctor network of independent, private practitioners, for more information, or to find a provider near you, please visit www.vsp.com. See below for a summary of plan benefits.

VSP Voluntary Plan Benefits:

Vision Service Plan Benefits	Vision Service Plan
Exam	Every 12 Months
Lenses** (Single vision, lined bifocal, and lined trifocal lenses)	Every 12 Months
Frames** (Frame of your choice covered up to $105. Plus, %20 off any out-of pocket costs)	Every 24 Months
-- OR -- Contacts	Every 12 Months

**Subject to a $20 co pay

VSP Voluntary Plan Monthly Rate Comparison:
(Rates are effective through 10/31/08)

Employee/Dependent Coverage	Vision Service Plan
Employee Only	$ 12.47
Employee + One Dependent	$ 19.38
Employee + Family	$ 30.74

ENROLLMENT INSTRUCTIONS

To apply for dental and/or vision benefits, complete the application by following these five simple steps.

- **Step 1** – Complete contact information.
- **Step 2** – Calculate your total monthly premium using the worksheet included on page 6. This amount will be your down payment and monthly premium amount (minus the setup fee where applicable).
- **Step 3** – Complete the Employee/Individual Enrollment Form (one for each employee/individual): Select the dental (only one non-voluntary plan per group, unlimited voluntary plans) and/or vision plan, fill out all employee/individual information and make sure to include any dependent information for the covered individual.
- **Step 4** – Each employee who chooses to waive coverage must complete the attached Waiver of Coverage Form. Please submit the originals with your application and keep a copy for your records.
- **Step 5** - Return the application, enrollment forms and any waivers, along with your first payment. You will receive a confirmation letter upon enrollment. 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 Full Time Employees: _____

*Total # of Enrollees: _____

Please note that for non-voluntary programs, all full time employees are required to participate in plans unless they provide a waiver of coverage. All waivers must accompany applications for coverage. Employees waiving coverage will not be eligible for benefits at a later date unless they can provide proof of a loss of prior coverage (see page 9 for Waiver of Coverage).

STEP 2 – MONTHLY PREMIUM CALCULATION WORKSHEET

(See Pages 2-4 for Rates)

DENTAL COVERAGE

NON-VOLUNTARY (Select *one* non-voluntary plan only per group)

Delta Dental PPO Plan A w/Ortho (3084-1000)		
Coverage Type	*# of Employees*	*Monthly Rate*
Employee Only		$ 48.82
+ 1 Dependant		$ 89.83
Family		$ 166.34

DeltaPremier Option 1 (3084-0077)		
Coverage Type	*# of Employees*	*Monthly Rate*
Employee Only		$ 50.18
+ 1 Dependant		$ 92.38
Family		$ 163.11

DeltaPremier Option 2 (3084-0047)		
Coverage Type	*# of Employees*	*Monthly Rate*
Employee Only		$ 40.49
+ 1 Dependant		$ 73.24
Family		$ 121.92

VOLUNTARY

DeltaPremier Voluntary		
Coverage Type	*# of Employees*	*Monthly Rate*
Employee Only		$ 29.00
+ 1 Dependant		$ 50.00
Family		$ 75.00

DeltaCare Voluntary		
Coverage Type	*# of Employees*	*Monthly Rate*
Employee Only		$ 25.00
+ 1 Dependant		$ 43.00
Family		$ 58.00

VISION PLAN PREMIUM

VSP Non-Voluntary		
Coverage Type	*# of Employees*	*Monthly Rate*
Employee Only		$ 11.49
+ 1 Dependant		$ 17.84
Family		$ 28.31

VSP Voluntary		
Coverage Type	*# of Employees*	*Monthly Rate*
Employee Only		$ 12.47
+ 1 Dependant		$ 19.38
Family		$ 30.74

TOTAL PREMIUM CALCULATION

Coverage	Total
Delta Dental Plan A	$
DeltaPremier Option 1	$
DeltaPremier Option 2	$
DeltaPremier Voluntary	$
DeltaCare Voluntary	$
VSP Non-Voluntary	$
VSP Voluntary	$
Setup Fee $10 (New Clients Only)	$
Admin ($1 per Employee, $5 Min.)	$
Total Amount Due	**$**

This section must be completed.

STEP 3 – EMPLOYEE/ INDVIDUAL ENROLLMENT

Please complete one form for each employee.

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: _____

Plan Choice(s):

☐ Delta Dental PPO Plan A w/ Ortho (3084-1000)

☐ Delta Premier Option 1 (3084-0077)

☐ Delta Premier Option 2 (3084-0047)

☐ DeltaPremier Voluntary

☐ DeltaCare Voluntary

☐ Vision Service Plan Non-Voluntary

☐ Vision Service Plan Voluntary

Enrollees:

☐ Employee Only

☐ Employee + One

☐ Employee + Family

Employee Signature: _____ Date: _____

STEP 4 – PAYMENT AND BILLING INFORMATION

Make checks payable to: **Capitol Association Plans**

Mail Payments to: P.O. Box 3040
Fair Oaks, CA 95628-9403

WAIVER OF COVERAGE

I do hereby attest that I have been offered the opportunity to participate in

_____'s Dental and/or Vision Insurance Plans (if eligible).
(Name of Company)

I do not wish to participate in the plan(s) I have checked below. I understand that I will not be eligible to join the below checked plans (if eligible) at a later date, unless I can provide proof of a loss of prior coverage.

Coverage(s) waived:

- ❍ Delta Dental
- ❍ Vision Service Plan

Reason for waiving coverage:

- ❍ I (and my dependents) are covered by my spouse's plan
- ❍ Other _____

Print Name: _____

Signature: _____

Date: _____

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