Capitol Association Plans
P.O. Box 3040, Fair Oaks, CA 95628-9403
Phone: (916) 944-1707 Fax: (866) 334-5346
E-mail: caps@capsplans.com
CA License Number: 0636993

CAPCA Voluntary Dental & Vision Enrollment Form

Thank you for your interest in a "Voluntary" Dental Plan for members of the **California Association of Pest Control Advisors** (CAPCA). No employer contribution is required for a voluntary plan. 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/. (NOTE: Employers of two or more people may be interested in our employer plans under "CAPCA Employer Dental & Vision Enrollment.")

DENTAL PLANS:

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 PMI
Employee Only	$ 29.00	$ 25.00
Employee + One	$ 50.00	$ 43.00
Employee + Family	$ 75.00	$ 58.00

VISION PLANS:

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 4. This amount will be your down payment.
- **Step 3** – Complete the Enrollment Form for each individual applying for coverage. Select the dental and/or vision plan, fill out all employee/individual information and make sure to include any dependent information for the covered individual.
- **Step 4** – Select your preferred method of payment.
- **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 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		$ 25.00
+ 1 Dependant		$ 43.00
Family		$ 58.00

VISION PLAN PREMIUM

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

TOTAL PREMIUM CALCULATION

Coverage	Total
DeltaPremier Voluntary	$
DeltaCare PMI Voluntary	$
VSP Voluntary	$
Setup Fee $10 (New Clients Only)	$
Total Amount Due	**$**

This section must be completed.

NOTE: There is a monthly administration fee of $1 per Employee (with a $5 minimum). This fee is waived for initial setup.

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	Vision Service Plan
Employee Only	☐	☐	☐
Employee + One	☐	☐	☐
Employee + Family	☐	☐	☐

*Rates are effective through 10/31/08

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: _____

STEP 4 – PAYMENT AND BILLING INFORMATION

Please select preferred method of payment:

☐ Check/Money Order
Make Checks Payable to Capitol Association Plans
Mail Payments to P.O. Box 3040, Fair Oaks, CA 95628-9403

☐ Automatic Bank Debit (ACH)
Please complete ACH authorization form on page 7.

☐ *Credit Card
☐ Visa ☐ MasterCard ☐ Discover

Card Number:	
Expiration Date:	
Name on Card:	
Address Line 1:	
Address Line 2:	
Phone:	
Signature	

***** By selecting the credit card option and signing above, you are authorizing Capitol Association Plans to charge your credit card on the 10th of each month. *If you wish to cancel this transaction, you must notify Capitol Association Plans in writing at least 10 days in advance.* If you select credit card billing your credit card will be billed automatically. You will not be mailed an invoice; if you would like a copy of your invoice, one can be mailed upon request. **PLEASE NOTE: Each credit card is subject to a transaction fee *per month* ($2.00 for individuals, $4.00 for families)**.

CAPITOL ASSOCIATION PLANS
PO Box 3040, Fair Oaks, CA 95628-1968
Phone: (916) 944-1707 Fax: (866) 334-5346
E-mail: caps@capsplans.com Website: www.capsplans.com

AUTOMATIC BANK DEBIT (ACH) AUTHORIZATION FORM
FAX TO: 866-334-5346

I authorize Capitol Association Plans to debit my bank account as follows:

☐ Automatically debit my bank account for my insurance premiums

☐ One time only bank account debit in the amount of $ _____

BILLING FREQUENCY (for automatic payments)

☐ Monthly ☐ Quarterly ☐ Bi-Annually ☐ Annually

BANK ACCOUNT INFORMATION

Bank: _____

Name on Account: _____

Bank Routing No.: _____

Checking Acct. No.: _____

Customer Address: _____

Daytime Phone: _____

Email Address: _____

Signature: _____

POLICIES & FEES:

If you select automatic billing, your account will be debited automatically by the 10th of the month which corresponds with your frequency of payment. You will not be mailed an invoice; however one can be mailed upon request. **NOTE: A $2.00 transaction fee for each ACH (automatic debit) will apply.**

If you wish to cancel this authorization, you must notify Capitol Association Plans in writing at least 10 days in advance of the scheduled transaction.