

# DentalandVisionIns.com

Dental and/or Vision Addition and Deletion Forms – 2 pages Revised 04-30-2009  
You can also submit additions, deletions and changes from our web site. Go to [www.DVIns.com](http://www.DVIns.com) and click on 'Manage Your Account'.

## Addition Form

Client I.D.: \_\_\_\_\_

Group Name: \_\_\_\_\_

- Add New Member  
 Add Dependents to an existing member

Please indicate the desired Effective Date: \_\_\_\_\_ - 01 - \_\_\_\_\_ Date Hired: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### 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: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

### 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: \_\_\_\_\_

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

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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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 Form

Client I.D.: \_\_\_\_\_

Group Name: \_\_\_\_\_

- Delete Member and all dependents
- Delete listed dependents only

Please indicate the desired effective date for the deletion of coverage: \_\_\_\_\_ - End of the 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

A group is subject to Federal COBRA regulations if they 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](http://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](http://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:  
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**Fax: 650-591-4022**