Capitol Association Plans
P.O. Box 214190, Sacramento, CA 95821
Phone: (916) 944-1707 Fax: (866) 334-5346
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CA License Number: 0636993

CAPS Voluntary Dental & Vision Enrollment Form

Thank you for your interest in a "Voluntary" Dental 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 our website at www.capsplans.com. (NOTE: Employers of two or more people may be interested in our employer plans under "CAPS Employer Dental & Vision Enrollment.")

DENTAL PLANS:

Voluntary programs allow an individual and their dependents 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, DeltaPPO and DeltaCare.

CAPS 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	DeltaPPO	DeltaCare
Provider Network	16,500	1500+ Offices
Deductible	$50 Individual $150 Family	None
Complete series x-ray including bitewings	Plan Pays $53	Plan Pays 100%
Cleaning – adult or child	Plan Pays $43	Plan Pays 100%
Silver Filling – One Surface	Plan Pays $46	Member Pays $2
Single Tooth Extraction	Plan Pays $48	Member Pays $5
Root Canal Therapy, Front Tooth	Plan Pays $238	Member Pays $50
Crown – porcelain (with non-precious metal)	Plan Pays $190	Member Pays $100
Complete denture, upper	Plan Pays $302	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 10/31/2019)

Enrollee/Dependent Coverage	*DeltaPPO	*DeltaCare PMI
Enrollee Only	$ 39.00	$ 36.00
Enrollee + One	$ 65.00	$ 59.00
Enrollee + Family	$ 98.00	$ 82.00

VISION PLANS:

CAPS INDIVIDUAL: Superior Vision Voluntary Program

These programs provide no waiting periods to receive benefits. CAPS vision program offers you high quality eye care services that include an exam and lenses or contacts every 12 months and frames every 12 months.

CAPS vision benefits are provided by Superior Vision, the Nation's largest, most diverse provider network. MDs, ODs and most retail chains in-network (national and regional) with more one-hour and same day service. See below for a summary of plan benefits.

Superior Vision Voluntary Plan Benefits:

Superior Vision Plan Benefits	
Exam	Every 12 Months
Lenses* (Single vision, lined bifocal, lined trifocal lenses, progressive and lenticular)	Every 12 Months
Frames* (Frame of your choice covered up to $150. Plus, %20 off any out-of pocket costs)	Every 12 Months
-- OR -- Contacts	Every 12 Months

*Co-pays (Exam $0, Materials $20.00, Contact Lens fitting $25.00)

Superior Vision Voluntary Plan Monthly Rates:

Enrollee/Dependent Coverage	
Enrollee Only	$ 15.00
Enrollee + One Dependent	$ 23.00
Enrollee + Family	$ 36.00

CAPS INDIVIDUAL: VSP Voluntary Program

CAPS vision benefits are also 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:

Employee/Dependent Coverage	Vision Service Plan
Employee Only	$ 17.20
Employee + One Dependent	$ 26.72
Employee + Family	$ 42.38

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** – 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 3** – Calculate your monthly premium using the worksheet included. This amount will be your down payment
- **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 – ENROLLMENT FORM

(Please complete one form for each enrollee.)

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: ___________**

Enrollee/Dependent Coverage	*DeltaPPO	*DeltaCare/PMI	Superior Vision Plan	Vision Service Plan
Enrollee Only	☐	☐	☐	☐
Enrollee + One	☐	☐	☐	☐
Enrollee + Family	☐	☐	☐	☐

*Rates are effective through 10/31/2019

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 3 – MONTHLY PREMIUM CALCULATION WORKSHEET

DENTAL COVERAGE

DeltaPPO Voluntary		
Coverage Type	*# of Enrollee*	*Monthly Rate*
Employee Only		$ 39.00
+ 1 Dependant		$ 65.00
Family		$ 98.00

DeltaCare PMI Voluntary		
Coverage Type	*# of Enrollee*	*Monthly Rate*
Employee Only		$ 36.00
+ 1 Dependant		$ 59.00
Family		$ 82.00

SUPERIOR VISION PLAN PREMIUM

Superior Vision Voluntary		
Coverage Type	*# of Enrollee*	*Monthly Rate*
Employee Only		$ 15.00
+ 1 Dependant		$ 23.00
Family		$ 36.00

VSP Voluntary		
Coverage Type	*# of Enrollee*	*Monthly Rate*
Employee Only		$ 17.20
+ 1 Dependant		$ 26.72
Family		$ 42.38

TOTAL PREMIUM CALCULATION

Coverage	Total
DeltaPPO Voluntary	$
DeltaCare PMI Voluntary	$
Superior Vision 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 $5.00 per Enrollee. This fee is waived for initial setup.

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 214190, Sacramento, CA 95821

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

CAPITOL ASSOCIATION PLANS
PO Box 214190, Sacramento, CA 95821
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

Date: ________________________________

Bank: ________________________________

Name on Account: ________________________________

Bank Routing No.: ________________________________

Checking Acct. No.: ________________________________

Customer Address: ________________________________

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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.