Capitol Association Plans
PO Box 3040, Fair Oaks, CA 95628
Phone: (916) 944-1707 Fax: (866) 334-5346
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CVMA Employer Dental & Vision Enrollment Form

Thank you for your interest in the **California Veterinary Medical Association** (CVMA) dental and vision programs. Attached please find the necessary enrollment documents to get you started. Should you have any questions, please contact our office by phone at (916) 944-1707 or email at caps@capsplans.com.

DENTAL PLANS:

A. CVMA MEMBER EMPLOYERS: Delta Dental Non-Voluntary Program

Under this group plan, full-time employees (32+hrs) of CVMA members will have access to any Delta dentist, who encompass the entire Delta Dental network of dentists. By using a PPO dentist, the maximum annual benefit is increased. ***Unlike many other plans, there are no waiting periods to utilize benefits and the percentage paid by Delta Dental increases each year over a period of four years to reach 100%.*** 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. Employers must contribute a minimum of 50% to the employee's premium but are not required to contribute for dependent coverage.

B. CVMA 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, Delta PPO and DeltaCare.

	Nonvoluntary Plan A	Voluntary Delta PPO	DeltaCare
Provider Network	In Network/PPO Out of Network	In Network PPO Out of Network	1500+ Offices in Network
Deductible	In Network: $0 Out of Network: $25 Individual/ $75 Family	$50 Individual $150 Family	None
Complete series x-ray including bitewings	Plan Pays 70% 1st year, 80% 2nd year, 90% 3rd year and 100% thereafter (Based on calendar year)	Plan Pays $45	Plan Pays %100
Cleaning – adult or child		Plan Pays $36	Plan Pays %100
Silver Filling – One Surface		Plan Pays $35	Plan Pays %100
Single Tooth Extraction		Plan Pays $39	Member Pays $3
Root Canal Therapy, Front Tooth		Plan Pays $193	Member Pays $55
Crown – porcelain (with non-precious metal)	Plan Pays 50%	Plan Pays $163	Member Pays $90 – 240
Complete denture, upper	Plan Pays 50%*	Plan Pays $240	Member Pays $110
Orthodontic	Plan Pays 50% ($1,000 Max Per Child)	Not Covered	Requires Co-Payment $1,600 for Child $1,800 for Adult
Maximum Annual Benefit	In Network: $1,500 Out of Network: $1,000	$1,000	No Maximum, Except for Accidental Injury

*12 month waiting period on prosthodontics applies.

DELTA DENTAL MONTHLY RATE COMPARISON	Nonvoluntary Plan A	Voluntary PPO	*DeltaCare Rates are based on network service area. See chart below for locations.			
			Level 1 & 2	Level 3	Level 4	Level 5
Employee Only	$ 42.57	$ 30.28	$ 30.00	$ 30.50	$ 31.50	$ 61.00
Employee + One	$ 83.37	$ 54.63	$ 49.00	$ 50.50	$ 52.00	$ 93.59
Employee + Family	$ 142.73	$ 83.76	$ 72.50	$ 75.00	$ 77.00	$147.00

Level 1 & 2 – Los Angeles and Orange Counties

Level 3 – Alameda, Contra Costa, Fresno, Kern, Mariposa, Riverside, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara and Ventura Counties

Level 4 – Alpine, Amador, Calaveras, Colusa, El Dorado, Imperial, Inyo, Kings, Madera, Marin, Merced, Monterey, Napa, Nevada, Placer, Plumas, Sacramento, San Joaquin, San Luis Obispo, Santa Barbara, Sierra, Solano, Sonoma, Stanislaus, Tuolumne, Tulare, and Yolo Counties

Level 5 – Butte, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Mono, San Benito, Santa Cruz, Shasta, Siskiyou, Sutter, Tehama, Trinity, and Yuba Counties

*Rates are effective through 10/01/2023

VISION PLANS:

As with the Dental plans, we have non-voluntary and voluntary programs for you and your employees to choose from. The voluntary program is available to all individual CVMA members and individual employees (including part-time employees), where the non-voluntary program is a group plan that is only to available employers and their full-time employees.

Coverage	Plan A (Non-Voluntary)	Plan B (Voluntary)
Exam	Every 12 Months	Every 12 Months
Prescription Glasses		
Lenses (Single vision, lined bifocal, and lined trifocal lenses)	Every 24 Months	Every 12 Months
Frames (Frame of your choice covered up to $120. Plus, %20 off any out-of pocket costs)	Every 24 Months	Every 24 Months
-- OR -- Contacts	Every 24 Months	Every 12 Months

VISION SERVICE PLAN MONTHLY RATE COMPARISON	Plan A (Non-Voluntary)	Plan B (Voluntary)
Employee Only	$8.23	$10.37
Employee + One Dependent	$12.79	$ 16.10
Employee + Family	$20.29	$ 25.55

*Rates are effective through 10/01/2023

ENROLLMENT INSTRUCTIONS

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

- **Step 1** – Complete contact information.
- **Step 2** – Select you preferred method of billing and payments. Please also make sure to calculate your total premium at the bottom of the page, as this will be your down payment and monthly premium amount (see Step 3 for plan selections and rates).
- **Step 3** – Select the plan(s) you would like to sign up for and how many employees will be enrolled in each plan.
- **Step 4** - Complete Employee / Individual Enrollment Form for each individual applying for coverage. Make sure to include any dependent information. It is important to note that for Non-Voluntary Plans dependents cannot be added to the plan after initial enrollment unless there they suffer a loss of coverage.
- **Step 5 -** 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 6** - Return the application, enrollment forms and waivers, along with your first payment to us to begin coverage. You will receive a confirmation letter once you have been enrolled. 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.

CVMA DENTAL & VISION ENROLLMENT

STEP 1 – CONTACT INFORMATION (please print)

CVMA Member: _____

Company (If applicable): _____

Billing Contact: _____

Address: _____

City, State, Zip: _____

Phone/ Fax: _____

E-mail: _____

*Total # of Full Time Employees: _____

*Total # of Enrollees: _____

Please note that 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 Waiver of Coverage).

STEP 2 – PAYMENT AND BILLING INFORMATION

Please select preferred method of billing (how you would like to receive your statements):

☐ Regular Mail ☐ Email

Please select preferred method of payment:

☐ Check/ Money Order
Make Checks Payable to Capitol Association Plans
Mail Payments to P.O. 214190, Sacramento, CA 95821

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

BILLING FREQUENCY

☐ Monthly ☐ Quarterly ☐ Bi-Annually ☐ Annually

PREMIUM CALCULATION

Coverage	Total
Delta Dental Plan A	$
Delta (PPO) Voluntary	$
DeltaCare Voluntary	$
VSP Plan A	$
VSP Plan B Voluntary	$
**Setup Fee $10 (New Accounts Only)	$
Admin ($1 per Employee, $5 Min.)	$
Add ACH $2.00	**$**
Total Amount Due	**$**

This section must be completed and returned.

STEP 3 – SELECT PLAN(S)

DENTAL COVERAGE

NON-VOLUNTARY PROGRAM – PLAN A

Delta Dental		
Coverage Type	*# of Employees*	*Monthly Rate*
Employee Only		$ 42.57
+ One Dependent		$ 83.37
Family		$ 142.73

VOLUNTARY PROGRAM – PLAN B

Delta PPO		
Coverage Type	*# of Employees*	*Monthly Rate*
Employee Only		$ 30.28
+ One Dependent		$ 54.63
Family		$ 83.76

DeltaCare – see chart		
Coverage Type	*# of Employees*	*Monthly Rate*
Employee Only		
+ One Dependent		
Family		

VISION PLAN

Vision Service Plan – A – Non-Voluntary		
Coverage Type	*# of Employees*	*Monthly Rate*
Employee Only		$ 7.76
+ One Dependent		$ 12.05
Family		$ 19.12

Vision Service Plan – B - Voluntary		
Coverage Type	*# of Employees*	*Monthly Rate*
Employee Only		$ 9.09
+ One Dependent		$ 14.12
Family		$ 22.39

STEP 4 – 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:

Employee Signature: _____ Date: _____

Plan Choice(s):

☐ Delta Dental Plan A ☐ Delta PPO ☐ DeltaCare* ☐ VSP Plan A ☐ VSP Plan B

Employee/Dependent Coverage:

☐ Employee Only ☐ Employee + One ☐ Employee + Family

DeltaCare Enrollees – Please Note: *If you do not specify a dentist of your choice, a dentist will be automatically selected for you. Your dentist choice must be submitted no later than 7 days before the end of the month. For a list of DeltaCare Dentists, please visit www.deltadentalins.com*

Dentist Name _____ Dentist #: _____

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: _____

CAPITOL ASSOCIATION PLANS
PO Box 3040 Fair Oaks CA. 95628
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 future 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: _____

Date: _____

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.