

GROUP NUMBER  
Delta Dental: NY2545

## HOW TO ENROLL IN THE DENTAL PROGRAM OF BRICKLAYERS & ALLIED CRAFT WORKERS LOCAL 2

1. Complete the Enrollment Form below. Be sure to complete all the information requested on the form, including the type of enrollment you would like to choose (i.e. Member Only, Member & One Dependent, Member & Family).
2. Make your check for the first month's premium to Wolfpack Insurance Services, Inc. The amount of the check will depend on the type of enrollment you choose. The chart on the enrollment form lists the ANNUAL and MONTHLY rates for each type of enrollment.
3. Send your completed form and your payment to: **Wolfpack Insurance Services, Inc.  
P.O. Box 720  
Belmont, CA. 94002-0720**
4. In order to be eligible for benefits in the contract year beginning MAY 1, 2007, your Enrollment Form and payment must be postmarked by May 1, 2007. In order to be eligible for benefits beginning the first of any month after MAY 1, 2007, your Enrollment Form and payment must be postmarked by the 15<sup>th</sup> of the prior month.
5. If you have any questions about enrolling in the dental program, please call 1-888-837-7511.

### DELTA DENTAL ENROLLMENT FORM

Bricklayers & Allied Craft Workers Local 2

ENROLLMENT TYPE	ANNUAL RATES	MONTHLY RATES
Member Only	\$491.64	\$40.97
Member & One Dependent	\$839.64	\$69.97
Member & Family	\$1,246.68	\$103.89

#### PLEASE PRINT

LAST NAME \_\_\_\_\_ MI \_\_\_\_\_ FIRST NAME \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ GENDER \_\_\_\_\_

TYPE OF ENROLLMENT:  Member & One Dependent  Member & Child  Member & Family

#### Please list eligible dependents to be covered in addition to yourself:

Spouse \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

Child \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

Child \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

Child \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

Child \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

Child \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

Remit your first month's payment and this completed form, which must be postmarked by the 15<sup>th</sup> of the month prior to your coverage effective date, to:

Wolfpack Insurance Services, Inc.  
P.O. Box 720  
Belmont CA 94002-0720

Please make check payable to: **WOLFPACK INSURANCE SERVICES, INC.**