EXPANDED DENTAL PLAN

Important information for HealthAmerica Federal Members

If you are currently enrolled in the Expanded Plan and you want to continue the coverage, you do not need to do anything. If you are in the Basic Plan and you want to switch to the Expanded Plan you must complete this enrollment form. For new members, your benefits will become effective the first pay in January. Your eligible dependents must enroll in the same plan in which you enroll in order for them to receive coverage. New hires or employees with a "change of life" event may enroll mid-year with benefits becoming effective on the first day of the month following Delta Dental's receipt of your enrollment form. Payroll deductions are *not* available. Enrollees must pay the premium (below) directly to Wolfpack Insurance Services, Inc., Delta Dental's administrator for monthly billing.

HOW TO ENROLL

1. Complete the Enrollment Form below. Be sure to complete all of the information requested on the form, including the type of enrollment you would like to choose (i.e., Enrollee Only or Enrollee & Family).
2. Make your check for the first month's premium payable to Wolfpack Insurance Services, Inc. The amount of the check will depend on the type of enrollment you choose. MONTHLY rates for each type of enrollment are listed below.
3. Send your completed form and your payment to:
   Wolfpack Insurance Services, Inc., P.O. Box 720, Belmont, CA 94002-0720.
4. During FEHB open season, in order to be eligible for benefits in the contract year beginning JANUARY 1, 2008 your Enrollment Form and payment must be postmarked by DECEMBER 10, 2007.
5. If you have any questions about enrolling in the dental program during FEHB open season, please call Delta Dental at 1-866-723-3582.

COMPLETE THIS ENROLLMENT FORM FOR THE HEALTHAMERICA EXPANDED DENTAL PLAN *(If you are currently enrolled in the HealthAmerica Federal Employees Expanded Plan and you want to continue your coverage without any changes, you do not need to complete this form. If you are choosing the Basic Plan, you do not need to complete this form.)*

You must be enrolled in the HealthAmerica Federal Employees medical plans.

ENROLLMENT TYPE	MONTHLY RATES
Self Only	**$20.98**
Self & Family*	**$42.77**

*Dependents/Students to age 22

(PLEASE PRINT)

Last Name ____________________________ First Name ____________________________ MI ______

Street Address____

City ______________________ State _______ ZIP ________ SSN _____________________________

Phone Number _____________________ Date of Birth: ______________________ Gender __________

Type of Enrollment (check one) ❏ Self Only ❏ Self & Family

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

Spouse _______________________________ Date of Birth ________ Gender _____

Dependent _______________________________ Date of Birth ________ Gender _____

Dependent _______________________________ Date of Birth ________ Gender _____

Dependent _______________________________ Date of Birth ________ Gender _____

Dependent _______________________________ Date of Birth ________ Gender _____

Dependent _______________________________ Date of Birth ________ Gender _____

Remit your first month's payment and this completed form to:

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

Please make check payable to:
Wolfpack Insurance Services, Inc.
Payroll deduction not available.