



HOW TO ENROLL IN INDEPENDENT HEALTH'S 55+ DENTAL PLAN

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. Individual or Individual and Spouse).
2. Make your check for the first month's premium to Wolfpack Insurance Services, Inc. The amount of the check will depend on which plan option you choose. The chart on the enrollment form lists the MONTHLY rates for each plan option.
3. Send your completed enrollment 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 beginning the first of any month, your Enrollment Form and payment must be postmarked by the 15th of the prior month.
5. If you have any questions about enrolling in the dental program, please call Wolfpack Insurance Services at 1-888-837-7511.

	MONTHLY RATES*	
ENROLLMENT TYPE	OPTION 1	OPTION 2
Individual	\$29.97	\$16.51
Individual & Spouse	\$53.40	\$28.15

*Dental rates are guaranteed for the 2007 and 2008 calendar years.

	PLAN BENEFITS	
SERVICES	OPTION 1	OPTION 2
DIAGNOSTIC	100%	100%
PREVENTIVE	100%	100%
BASIC RESTORATIVE	50%	50%
ORAL SURGERY	50%	50%
ENDODONTICS	50%	50%
SURGICAL PERIODONTICS	50%	Not Covered
NON-SURGICAL PERIODONTICS	80%	50%
MAJOR RESTORATIVE	50%	Not Covered
PROSTHODONTICS	50%	Not Covered
DENTURE REPAIR	80%	50%
TMJ	50%	50%
DEDUCTIBLE per person	\$0 per calendar year	\$100 per calendar year
MAXIMUM BENEFITS per calendar year	\$1500 per calendar year	\$1000 per calendar year

DELTA DENTAL ENROLLMENT FORM

Independent Health's 55+ Dental Plan

PLEASE PRINT

LAST NAME _____ MI _____ FIRST NAME _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY NUMBER _____

INDEPENDENT HEALTH ID # _____

(Enrollee must be a member of an Independent Health medical plan to join)

PHONE NUMBER _____ DATE OF BIRTH _____

(Enrollee must be at least 55 years old when coverage becomes effective)

GENDER _____

TYPE OF ENROLLMENT: Individual Individual & Spouse

PLAN PREFERENCE: Option 1 Option 2

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

Spouse _____

Date of Birth _____ Gender _____

(Enrollee's spouse must be at least 55 years old when coverage becomes effective)

Remit your first month's payment and this completed form, which must be postmarked by the 15th 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.**

I have read the information contained in this application and choose to enroll in **Independent Health's 55+ Dental Plan**, group NY6807 or NY6808. I understand the benefits and restrictions of Independent Health's 55+ Dental Plan as stated to me and/or explained in the material provided with the application. I understand that my enrollment is subject to receipt of payment and verification of funds. Eligibility will begin on the first day of the month following receipt of the enrollment form if postmarked by the 15th of the prior month (otherwise eligibility will begin on the first day of the second month following receipt of the enrollment form). I understand that if I discontinue my enrollment, I will not be eligible to re-enroll within a 12-month period following termination. I hereby certify that the information contained in this application is true and complete.

X _____

Applicant Signature

Date

Standard Limitations and Exclusions

Limitations

- Periodic examinations of the full mouth are limited to twice in any calendar year.
- Bitewing x-rays are limited to twice in any calendar year.
- Full mouth x-rays and panorex x-rays accompanied by bitewing x-rays are limited to once in any 3-year period.
- Prophylaxes are limited to twice in any calendar year.
- Benefits for specific oral surgery procedures, such as the reduction of fractures, removal of tumors, and removal of impacted teeth, which are benefited under a medical insurance contract or a medical or hospital service contract for which premiums are paid by the Plan Administrator by which you are covered shall be determined first under that contract. Delta Dental's obligation for these oral surgery services shall be limited to the difference between benefits paid under the other contracts up to the Allowed Amount for the procedure less the applicable deductible and patient copayment. When coverage is not paid for by the Plan Administrator or there is no medical or hospital coverage, Delta Dental's obligation shall be subject to coordination of benefits or limited to the Allowed Amount for the procedure less the applicable deductible and patient copayment.
- Dental benefits may be based on the least costly treatment that conforms to generally accepted dental practice.
- *For option 1 only*, Replacement of restorative crowns, inlays and onlays is a benefit once only in any 5-year period irrespective of who provided previous restoration or paid benefits therefore.
- *For option 1 only*, Prosthodontic appliances and abutment crowns will be replaced only after 5 years have elapsed following any prior provision of such appliances and abutment crowns under any plan procedure.
- *For option 1 only*, replacement of an existing denture will be made only if it is unsatisfactory and cannot be made satisfactory. Services which are necessary to make such appliances fit will be provided in accordance with the Group Dental Service Contract.
- *For option 1 only*, benefits for periodontal surgery in the same quadrant are limited to once in any 5-year period. The 5-year period shall be measured from the date on which the last periodontal surgery was performed in that quadrant, whether paid for under the provisions of this Contract, under any prior dental contract, or by you.

Exclusions

- Services or supplies which are provided to patient by any federal or state government agency or by any municipality, county, or other political subdivision.

- Charges for which benefits or services are provided to the patient by any hospital, medical or dental service corporation, any group insurance, franchise, or other prepayment plan for which an employer, union, trust or association makes contributions or payroll deductions (unless the coordination of benefit provisions provide otherwise).
- Charges for dental practice administrative services including but not limited to preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton, swabs, gauze, bibs, masks or relaxation techniques such as music.
- General anesthesia, except with covered oral surgery procedures of one or more simple extractions and/or with surgical extractions for patients under age 19; and except with three or more simple extractions and/or one or more surgical or impacted extractions for patients age 19 and over.
- Composite restorations in molar posterior teeth. If posterior composite restorations are provided on molar teeth, Delta Dental will pay the allowance for an amalgam restoration and the patient will be responsible for the additional cost.
- Procedures to correct congenital or developmental malformations except for dependent children or newborn children eligible at birth.
- Treatments or devices that increase the vertical dimension of an occlusion, restore an occlusion to normal, replace tooth structure lost by attrition or erosion, or otherwise.
- Treatments or supplies primarily for cosmetic purposes.
- Services provided or supplies furnished or devices started prior to the effective eligibility date of a patient.
- Preventive plaque control programs, including oral hygiene programs.
- Fissure sealants unless covered under the group contract.
- Space Maintainers
- Periodontal splinting, equilibration and gnathological recordings.
- Myofunctional therapy.
- Implants.
- Replacement of existing restorations for any purpose other than restoring active carious lesions or demonstrable breakdown of the restoration.
- Prescription drugs, pre-medication, analgesias, and general anesthesia, unless covered under the group contract.
- Treatment or supplies for which the patient would have no legal obligation to pay in the absence of this or any other similar coverage.
- Experimental procedures which have not been accepted by the American Dental Association.
- Orthodontic services, including tooth guide appliances.
- *For option 2 only*, major restorative services – inlays, onlays, crowns
- *For option 2 only*, surgical periodontics
- *For option 2 only*, Prosthodontic services, including bridges, dentures.