

HOW TO ENROLL IN IRON WORKERS LOCAL 401 (RETIREES) DENTAL PLAN

1. Complete the Enrollment Form on the back. Be sure to provide all the information requested on the form, including the type of enrollment you would like to choose (i.e., Retiree only, Retiree and one dependent, Retiree and family).
2. Make your check for the first month's premium payable to *Wolfpack Insurance Services, Inc.*, Delta Dental's enrollment administrator. The amount of the check will depend on the type of enrollment you choose. The chart below lists the MONTHLY rates for each type of enrollment.
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 for you to be eligible for benefits beginning the first of any month, your Enrollment Form and payment must be postmarked by the 10th of the month prior to the month in which you would like to be enrolled.
5. If you have any questions about enrolling in the dental program, please call Wolfpack Insurance Services at 1-888-837-7511.

| ENROLLMENT TYPE | MONTHLY RATES* |
|---------------------------|----------------|
| Retiree only | \$22.51 |
| Retiree and One Dependent | \$35.84 |
| Retiree and Family | \$52.05 |

*Dental rates are guaranteed from February 1, 2010, through January 31, 2011.

Please refer to Copayment Schedule for Benefits.



DELTA DENTAL ENROLLMENT FORM
Iron Workers Local 401 Retirees Dental Plan

PLEASE PRINT

LAST NAME _____ FIRST NAME _____ MI _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY NUMBER _____

PHONE NUMBER _____ DATE OF BIRTH _____

GENDER _____

TYPE OF ENROLLMENT: Retiree Retiree & One Dependent Retiree & Family

EFFECTIVE DATE OF COVERAGE: _____

Please list eligible dependent(s) to be covered in addition to yourself:

Spouse Name _____
Date of Birth _____ Gender _____

Dependent Name _____
Date of Birth _____ Gender _____

Dependent Name _____
Date of Birth _____ Gender _____

Dependent Name _____
Date of Birth _____ Gender _____

DeltaCare® USA Primary Care Dentist: _____
Primary Dental Office ID Number: _____

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

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

Your enrollment form must be postmarked by the 10th of the month prior to the month in which you would like to be enrolled

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

