

CARA DeltaCare Enrollment Instructions

- Complete the **Employer Application** form and select *ONE* plan design for the entire employer group.
- Each enrolling employee needs to complete an **Enrollment/Change Form**.
- If the enrolling employee does not elect to cover their dependents, then dependents may not enroll later unless there is a qualifying event.
- Each member should name a dental provider of their choice. Providers can be changed if the carrier is notified by the **15th** of the month. Changes will be made effective on the first of the following month.
- All employer groups will be made effective on the first of any given month.
- Applications must be received by the **20th** of each month for a first of the following month effective date.
- This plan focal renews on **January 1** of every year.
- Include first month's premium check and applicable billing fee. Make check payable to **CARA**.
- Submit all forms to **AIS** for processing:
AIS
One Kaiser Plaza, Suite 1333
Oakland, CA 94612
Attn: New Business
- For questions, call AIS at (800) 788-6524.

CARA DELTACARE

Voluntary Plan HMO 12A

Employer Group Information

Effective Date :

Group Name :	
Address :	
City, State, Zip :	
Contact Person :	
Phone :	Fax :
Email :	

Monthly Rates Effective 1/1/2012 through 12/31/2012

Region 1 & 2 covers the following counties:

Los Angeles & Orange

Region 3 covers the following counties:

Alameda, Contra Costa, Fresno, Kern, Mariposa, Riverside, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara & Ventura

Region 4 covers the following counties:

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, Stanislaus, Tuolumne, Tulare & Yolo

Region 5 covers the following counties:

Butte, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Mono, San Benito, Santa Cruz, Shasta, Siskiyou, Sutter, Tehama, Trinity & Yuba

Plan 12A	<input type="checkbox"/> Region 1 & 2	<input type="checkbox"/> Region 3	<input type="checkbox"/> Region 4	<input type="checkbox"/> Region 5
Member Only	\$ 20.90	\$ 21.44	\$ 21.92	\$ 43.83
Member + 1 Dependent	\$ 34.49	\$ 35.37	\$ 36.18	\$ 72.31
Member + 2 Dependents or more	\$ 51.00	\$ 52.29	\$ 53.49	\$ 106.94
				Subtotal \$
<input type="checkbox"/> ACH <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually				Administration Fee * \$
Note: ACH groups – Please complete the ACH form.				Grand Total \$

Please make check payable to "CARA"

* Please refer to ***AIS Administration Fee Schedule*** for your choice of billing option.

Broker Information

AIS Broker Number :	
Broker Name :	
Firm Name :	
Address :	
City, State, Zip :	
Phone :	Fax :
Email :	

Please mail to: AIS * One Kaiser Plaza, Suite 1333 * Oakland, CA 94612 * Attn: New Business



ENROLLMENT/CHANGE FORM

FOR EMPLOYER USE ONLY

Group No. _____

Contract Type _____

Effective Date _____

Check One

- New Enrollment New Social Security Number/
Employee ID Number
- Name Change
- Facility Change* Address Change
- COBRA Add Dependent
- Remove Dependent

Indicate effective date of change:
*(Does not pertain to facility change)

____ (Month) ____ (Day) ____ (Year)

COBRA Enrollment Only

Please indicate qualifying event:

- Termination Widowed Surviving Dependent
- Divorce Overage Dependent

Indicate qualifying date:

____ (Month) ____ (Day) ____ (Year)

Primary Enrollee Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: _____ (Last) _____ (First) _____ (M.I.)

Mailing Address: _____ (Street Address)
 _____ (City) _____ (State) _____ (Zip Code)

Date of Birth: _____ (Month) _____ (Day) _____ (Year) Male Home Phone #: (____) _____ - _____
 Female

Name of Employer/Group: _____

Location: _____

Soc. Security #: _____ - _____ - _____ Employee Identification #: _____

Contract Facility Name: _____ Contract Facility #: _____

Dependent Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (To add additional dependents, please attach a separate sheet.) Note: You may choose up to three separate offices for yourself and all dependent enrollees.

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF

Relationship Code*	Dependent Name	Male/ Female	Date of Birth	Contract Facility Name	Contract Facility #:
		(Check One) M F	(Month) (Day) (Year)		
		<input type="checkbox"/> <input type="checkbox"/>			
		<input type="checkbox"/> <input type="checkbox"/>			
		<input type="checkbox"/> <input type="checkbox"/>			
		<input type="checkbox"/> <input type="checkbox"/>			
		<input type="checkbox"/> <input type="checkbox"/>			
		<input type="checkbox"/> <input type="checkbox"/>			
		<input type="checkbox"/> <input type="checkbox"/>			
		<input type="checkbox"/> <input type="checkbox"/>			

*Relationship Codes: Place the following two character code in the first column to designate each dependent as follows:

Spouse - SP Domestic Partner - DP Child - CH Child of DP - CD Other Adult - OA Other Child - OC

Signature of Primary Enrollee _____ Date _____

CARA Membership Application

The undersigned, whose address and telephone number are shown below, hereby makes application for membership in CARA, an unincorporated association, upon the terms and conditions herein provided.

Upon payment of the membership application fee in the amount of \$15.00 and acceptance by CARA, the undersigned shall be entitled to all privileges and benefits as a CARA member, including participation in all CARA sponsored insurance programs for which such member shall be qualified and accepted.

In order to sustain membership in CARA, the member shall pay to CARA each year on or before the anniversary date of enrollment shown below, the annual dues established by the CARA Board of Directors. Said association dues shall be used by CARA solely for and in consideration of membership in the association.

The undersigned agrees to abide by the association's laws and such other membership rules as may be promulgated by the CARA Board of Directors from time to time.

Group Name: _____

Address: _____

City & Zip: _____

Signature: _____

Title: _____

Date: _____

Telephone Number: _____

For internal use:

Accepted by CARA _____

Signature



(In Nevada, also known as EWC Insurance Services, Inc.)

Administration Fee Schedule

ACH (Auto Bank Draft) *	Monthly
1 Employee	\$ 3.50
2 to 4 Employees	\$ 3.50
5 > Employees	\$ 3.50
CARA Membership Fee	Included

* ACH groups will not receive any monthly statements.

** ONE person groups may elect only ACH or By Mail (Semi-Annual or Annual) payment modes.

By Mail	Monthly	Quarterly	Semi-Annually	Annually
1 Employee	n/a	n/a	\$ 25.00	\$ 25.00
2 to 4 Employees	\$ 10.00	\$ 20.00	\$ 25.00	\$ 25.00
5 > Employees	\$ 20.00	\$ 30.00	\$ 25.00	\$ 25.00
CARA Membership Fee **	\$ 15.00	\$ 15.00	\$ 15.00	\$ 15.00

** If you select By Mail, you will be charged CARA Membership Fee on the anniversary month.

Please make check payable to **“CARA”**.

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH DEBITS)

E.W.C. INSURANCE SERVICES, INC. DBA AIS

I (we) hereby authorize E.W.C. Insurance Services, Inc. DBA AIS, hereinafter called COMPANY, to initiate *debit entries* to my/our CHE CKING acc ount indicated below at the Depository Finan cial Institution named below, hereinafter called DEPOSITORY, and to debit the same to such account on the 5th or 20th of each m onth (select one). I (we) acknowledge t that the origination of A CH transactions to my (our) account must comply with the provisions of U.S. law.

DEPOSITORY NAME _____ BRANCH _____

CITY _____ STATE _____ ZIP CODE _____

ROUTING# _____ ACCOUNT# _____

This authoriz ation is to re main in full fo rce and effect until COMP ANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable oppo rtunity to act on it.

NAME(S) _____ CLIENT # _____
FOR INTERNAL USE ONLY

DATE _____ SIGNED X _____

NOTE: All written debit authorization MUST provide that the receiver may revoke the authorization only by notifying the originator in the manner specified in the authorization within 30 days. This form is to be submitted along with 1st month's premium and/or a copy of 'VOID' check.

sample check

Any Name	2345
1234 Any Street	DATE _____
City, State Zip Code	
Pay to the order of _____	Dollars
_____ Dollars	
Bank Name	
Main Branch	
1234 Any Street	
City, State Zip Code	
(800) 555-1234	
:123456789 : 2345 ""1234567890	

↑ Routing Number ↑ Account Number