NORTH RANCH BENEFITS TRUST
POWERED BY WARNER PACIFIC

Return enrollment forms to:
HealthSmart Benefit Solutions, Inc.
Phone: (800) 786-6525 Fax: (303) 804-9490
Email: NRBT@healthsmart.com

HealthSmart
SMARTER HEALTHCARE SOLUTIONS

North Ranch Benefits Trust
Dental and/or Vision Employee Enrollment/Change Form

Group administrator should return completed forms to HealthSmart within 30 days of Qualifying Event. Missing information could delay processing.

Vision Service Plan: ☐ _____ **Print Plan Name** **Ameritas Dental:** ☐ **PPO** **Delta Dental:** ☐ **Premier** ☐ **PPO** ☐ **HMO - DeltaCare**	Look up Providers at: www.vsp.com www.ameritasgroup.com www.deltadentalins.com	Requested Effective Date (First of the month only)

DeltaCare HMO Enrollment Only (choose dentist office)

DENTAL OFFICE NAME	DENTAL OFFICE CITY	DENTAL OFFICE ID#

Employer Information

GROUP NAME		GROUP/DIVISION #		
CONTACT PERSON		TITLE		
CONTACT EMAIL		CONTACT PHONE #		
OUR GROUP'S WAITING PERIOD FOR NEW HIRES IS FIRST OF MONTH FOLLOWING:	☐ **Date of Hire**	☐ **1 month**	☐ **2 months**	☐ Other:

Reason for Enrollment (Qualifying Event) or Change (CHECK ONE BOX FROM THE FIRST ROW AND THEN ONE BOX FROM THE SECOND FOR COBRA STATUS)

☐ New Hire ☐ Rehire ☐ Part-time to Full-time	☐ Marriage/Domestic Partnership ☐ Divorce ☐ Birth/Adoption	☐ Loss of Other Group Coverage: please provide a letter from the carrier or employer for proof of loss	☐ Name Change ☐ Social Security correction ☐ Address Change ☐ Other _____

☐ **Our group is Federal COBRA eligible**
Federal COBRA Enrollment Administered by Employer

☐ **Our group is State COBRA Enrollment (If applicable)** Administered by HealthSmart if member elects.
Please send offer to terminated member. Y or N.

DENTAL NOTE: Eligible employees electing for themselves must enroll following completion of the groups waiting period. Employees who do not enroll **cannot enroll at later date** unless they show proof of loss of prior coverage under another dental program. Enrollees electing dependent coverage must enroll all eligible dependents. Enrollees declining dependent coverage **cannot enroll their dependents at a later time** unless the dependents show proof of loss of prior coverage.

Member Information

FIRST NAME, LAST NAME			SOCIAL SECURITY #	
STREET ADDRESS	CITY		STATE	ZIP CODE
PHONE NUMBER	☐ **Male** ☐ **Female**	DATE OF BIRTH (MMDDYY)		DATE OF HIRE (MMDDYY)

Dependents To Be Enrolled

SPOUSE/DOMESTIC PARTNER'S FIRST NAME, LAST NAME	☐ **Male** ☐ **Female**	DATE OF BIRTH (MMDDYY)	☐ **Spouse** ☐ **Domestic Partner**
CHILD'S FIRST NAME, LAST NAME	☐ **Male** ☐ **Female**	DATE OF BIRTH (MMDDYY)	
CHILD'S FIRST NAME, LAST NAME	☐ **Male** ☐ **Female**	DATE OF BIRTH (MMDDYY)	
CHILD'S FIRST NAME, LAST NAME	☐ **Male** ☐ **Female**	DATE OF BIRTH (MMDDYY)	
CHILD'S FIRST NAME, LAST NAME	☐ **Male** ☐ **Female**	DATE OF BIRTH (MMDDYY)	

Member Signature	Date