

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: <input type="checkbox"/> _____ Print Plan Name	Look up Providers at: www.vsp.com	Requested Effective Date (First of the month only)
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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:		<input type="checkbox"/> Date of Hire	<input type="checkbox"/> 1 month	<input type="checkbox"/> 2 months
		<input type="checkbox"/> 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)				
<input type="checkbox"/> New Hire	<input type="checkbox"/> Marriage/Domestic Partnership	<input type="checkbox"/> Loss of Other Group Coverage: please provide a letter from the carrier or employer for proof of loss	<input type="checkbox"/> Name Change	
<input type="checkbox"/> Rehire	<input type="checkbox"/> Divorce		<input type="checkbox"/> Social Security correction	
<input type="checkbox"/> Part-time to Full-time	<input type="checkbox"/> Birth/Adoption		<input type="checkbox"/> Address Change	
			<input type="checkbox"/> Other _____	
<input type="checkbox"/> Our group is Federal COBRA eligible Federal COBRA Enrollment Administered by Employer		<input type="checkbox"/> Our group is State COBRA Enrollment (If applicable) Administered by HealthSmart if member elects. Please send offer to terminated member. Y or N.		
<p>DENTAL NOTE: Eligible employees electing for themselves must enroll following completion of the groups waiting period. Employees who do not enroll <u>cannot enroll at later date</u> 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 <u>cannot enroll their dependents at a later time</u> unless the dependents show proof of loss of prior coverage.</p>				

Member Information				
FIRST NAME, LAST NAME			SOCIAL SECURITY #	
STREET ADDRESS		CITY	STATE	ZIP CODE
PHONE NUMBER		<input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH (MMDDYY)	DATE OF HIRE (MMDDYY)

Dependents To Be Enrolled			
SPOUSE/DOMESTIC PARTNER'S FIRST NAME, LAST NAME	<input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH (MMDDYY)	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner
CHILD'S FIRST NAME, LAST NAME	<input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH (MMDDYY)	
CHILD'S FIRST NAME, LAST NAME	<input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH (MMDDYY)	
CHILD'S FIRST NAME, LAST NAME	<input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH (MMDDYY)	
CHILD'S FIRST NAME, LAST NAME	<input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH (MMDDYY)	

Member Signature	Date