NORTH RANCH BENEFITS TRUST

Change Request Form – Dental and Vision

NORTH RANCH BENEFITS TRUST
POWERED BY WARNER PACIFIC

Employer Name:		Division #:	

1. Employee Information					
		Requested Effective Date:			
Employee First Name:		Employee Last Name:			
Social Security #:		Date of Hire:			
Mailing Address:					
City:		State:		Zip Code:	
Phone:		Email:			
Your email address will not be used for any purpose other than communications from NRBT.					

2. Change or Qualifying Event (provide reason below)

Date of Change or Qualifying Event:

☐ Marriage	☐ Divorce
☐ Domestic Partnership	☐ Address Change
☐ Birth	☐ Loss of Other Group Coverage: Proof of loss required.
☐ Adoption	☐ Other_____

All applications for Qualifying Events must be submitted to HealthSmart **within 60 days of the Qualifying Event**. The effective date will be the 1st of the month following receipt of application, waiting period, or qualifying event.

3. Coverage Selection

Voluntary Ameritas Dental	**Voluntary Delta Dental**	**Voluntary Humana Dental**	**Voluntary Vision Service Plan**	**Employer Sponsored Vision Service Plan**
☐ Ameritas Dental	☐ Delta PPO ☐ Delta Care DHMO*	☐ PPO ☐ PPO Traditional Preferred ☐ PPO Preventive Plus ☐ DHMO*	☐ Vision*	☐ Vision
	*DHMO Primary Dentist: _____ Locate provider at: www.deltadentalins.com	*DHMO Primary Dentist: _____ Locate provider at: www.humana.com	*List VSP Plan Name: _____	
☐ Employee ONLY ☐ Employee + 1 ☐ Employee + 2 or more	☐ Employee ONLY ☐ Employee + 1 ☐ Employee + 2 or more	☐ Employee ONLY ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family	☐ Employee ONLY ☐ Employee + 1 or Employee + Children ☐ Family	☐ Employee ONLY ☐ Employee + 1 or Employee + Children ☐ Family

4. Waiving Dental Waiting Periods

Dental plans have a 12 month major service waiting period for services. This may waived if proof of 12 months of continuous prior coverage is included with this application. Please provide a copy of your dental ID card with this application.

Who is your current dental carrier?			
Dates of coverage from:		**Dates of coverage to:**	

North Ranch Benefits Trust
Phone: (888) 833-9220 I Fax: (818) 351-8184 I Email: service@nrbt.com I Website: www.NRBT.com
CA license # 07642060 CO license # 351162 Eff. 1/1/16 – Rev. 6/22/16

NORTH RANCH BENEFITS TRUST

Change Request Form – Dental and Vision

NORTH RANCH BENEFITS TRUST
POWERED BY WARNER PACIFIC

Employer Name:		Division #:	

5. Employee Information							
Dental	Vision	First Name	MI	Last Name	Gender	Relationship	DOB MM/DD/YYYY
☐	☐				☐ M ☐ F	☐ SELF	
☐	☐				☐ M ☐ F	☐ SPOUSE ☐ DOMESTIC PARTNER	
☐	☐				☐ M ☐ F	☐ CHILD	
☐	☐				☐ M ☐ F	☐ CHILD	
☐	☐				☐ M ☐ F	☐ CHILD	
☐	☐				☐ M ☐ F	☐ CHILD	
Eligibility Note: Eligible employees, and their dependents, must enroll within 30 days of the group's new hire waiting period or a Qualifying Event.							

I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of my knowledge. I am at least 18 years of age. It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance carrier for the purpose of defrauding or attempting to defraud the carrier. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Division of Insurance within the Department of Regulatory Agencies.

EMPLOYEE SIGNATURE:	**X**	**DATE:**	

North Ranch Benefits Trust
Phone: (888) 833-9220 I Fax: (818) 351-8184 I Email: service@nrbt.com I Website: www.NRBT.com
CA license # 07642060 CO license # 351162 Eff. 1/1/16 – Rev. 6/22/16