

# NORTH RANCH BENEFITS TRUST

## Change Request Form – Dental and Vision



Employer Name:		Division #:	
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<b>1. Employee Information</b>		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.			

<b>2. Change or Qualifying Event (provide reason below)</b>	
Date of Change or Qualifying Event:	
<input type="checkbox"/> Marriage <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Birth <input type="checkbox"/> Adoption	<input type="checkbox"/> Divorce <input type="checkbox"/> Address Change <input type="checkbox"/> Loss of Other Group Coverage: Proof of loss required. <input type="checkbox"/> Other _____
All applications for Qualifying Events must be submitted to HealthSmart <b>within 60 days of the Qualifying Event</b> . The effective date will be the 1st of the month following receipt of application, waiting period, or qualifying event.	

<b>3. Coverage Selection</b>				
Voluntary Ameritas Dental	Voluntary Delta Dental	Voluntary Humana Dental	Voluntary Vision Service Plan	Employer Sponsored Vision Service Plan
<input type="checkbox"/> Ameritas Dental	<input type="checkbox"/> Delta PPO <input type="checkbox"/> Delta Care DHMO*	<input type="checkbox"/> PPO <input type="checkbox"/> PPO Traditional Preferred <input type="checkbox"/> PPO Preventive Plus <input type="checkbox"/> DHMO*	<input type="checkbox"/> Vision*	<input type="checkbox"/> Vision
	*DHMO Primary Dentist: _____ Locate provider at: <a href="http://www.deltadentalins.com">www.deltadentalins.com</a>	*DHMO Primary Dentist: _____ Locate provider at: <a href="http://www.humana.com">www.humana.com</a>	*List VSP Plan Name: _____	
<input type="checkbox"/> Employee ONLY <input type="checkbox"/> Employee + 1 <input type="checkbox"/> Employee + 2 or more	<input type="checkbox"/> Employee ONLY <input type="checkbox"/> Employee + 1 <input type="checkbox"/> Employee + 2 or more	<input type="checkbox"/> Employee ONLY <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family	<input type="checkbox"/> Employee ONLY <input type="checkbox"/> Employee + 1 or Employee + Children <input type="checkbox"/> Family	<input type="checkbox"/> Employee ONLY <input type="checkbox"/> Employee + 1 or Employee + Children <input type="checkbox"/> Family

<b>4. Waiving Dental Waiting Periods</b>	
Dental plans have a 12 month major service waiting period for services. This may be 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:

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5. Employee Information							
Dental	Vision	First Name	MI	Last Name	Gender	Relationship	DOB MM/DD/YYYY
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> SELF	
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> SPOUSE <input type="checkbox"/> DOMESTIC PARTNER	
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> CHILD	
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> CHILD	
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> CHILD	
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> 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:	
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