

NORTH RANCH BENEFITS TRUST

Change Request Form – Vision



Employer Name:		Division #:	
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1. Employee Information		Requested Effective Date:	
Employee First Name:		Employee Last Name:	
Social Security #:		Date of Hire:	
Mailing Address:			
City:		State:	
Phone:		Zip Code:	
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:	
<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 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. Plan Selection. Options available are based upon your employer's offering.	
Voluntary Vision Service Plan <input type="checkbox"/> Vision*	Employer Sponsored Vision Service Plan <input type="checkbox"/> Vision
*List VSP Plan Name: _____ Locate provider at: www.vsp.com	Locate provider at: www.vsp.com
<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

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