NORTH RANCH BENEFITS TRUST

Employer Application – Dental and Vision

Employer Name:		Division #:	

1. Employer Information					Requested Effective Date:	
Company Name:					DBA:	
Company Tax ID:					SIC Code:	
Mailing Address:						
City:		State:		Zip Code:		
Billing Address (if different):						
City:		State:		Zip Code:		
Contact Person:		Phone:				
Email:		What is your communication preference? ☐ Mail ☐ Email				

2. Group Eligibility Information

Total # of Employees:	Total # of Eligible Employees:	Total # of Enrolling Employees:

Eligibility waiting period for future employees is first of the month following:

☐ Date of Hire ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other:_____

Is your group currently subject to:

☐ Federal COBRA (Employed 20+ eligible employees on at least 50% of its working days in the previous calendar year*)

☐ State COBRA (Employed 2-19 eligible employees on at least 50% of its working days in the previous calendar year*)

*Check with your State Department of Labor for local eligibility rules or visit www.DOL.gov for more COBRA eligibility information.

3. Invoice and Payment Preferences

Invoices:	☐ Mailed *and/or* ☐ Emailed (Email to: _____ or ☐ Same email as
Initial Payment Mode:	☐ Check ☐ ACH Draft (complete section 4)
Ongoing Payment Mode:	☐ Check paid monthly – due by the 1st business day of each month ☐ ACH Draft paid monthly – Drafted on the 1st business day (complete section 4)

Initial Payment: Initial payment is required. Please make check payable to ***HealthSmart Benefit Solutions, Inc.*** Future payments can be mailed to HealthSmart Benefit Solutions, Inc., P.O. Box 17768, Denver, CO 80217-0768.
Ongoing Payment: This is a prepaid plan and monthly payments are due no later than the first day of the coverage month. Late fees will apply if not paid by the 15th of month due and group is subject to cancellation if not paid by last day of month due.

Monthly Administration Fee:	**$15.00 administration fee will apply to invoice each month.**

4. ACH Payment Authorization

Account Holder's Name		Name of Bank	
Bank Address			
Bank Routing Number		Account Number	

☐ **Please attach a voided check**

I am authorizing **HealthSmart Benefit Solutions, Inc.** to initiate debits from my checking account named above. This authority will remain in effect until I notify them in writing to cancel it in such time as to afford the financial institution a reasonable opportunity to act on it. I can stop payment of any entry by notifying my financial institution (7) days before my account is charged. Any questions, contact HealthSmart at (800) 786-6525. **Please attach a copy of a voided check.**

Signature of Company Officer:	**X**	**Title:**	
Name (print):		**Date:**	

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5. Vision Coverage Selection

Employer Sponsored Vision Service Plan
Minimum of three employees required at all times.

Rates effective January 1, 2017 through December 31, 2017. This plan renews every January.

Choose ONE Plan	Plan #	Plan Name	Employee Only	EE + 1 or Employee + Children	EE + Family
☐	0080	Choice A $0 12/24/24	$7.93	$13.03	$20.97
☐	0081	Choice B $0 12/12/24	$11.12	$16.92	$27.28
☐	0066	Signature A $25 12/24/24	$8.68	$13.18	$21.28
☐	0002	Signature B $25 12/12/24	$10.86	$16.52	$26.61
☐	0069	Signature C $25 12/12/12	$13.27	$20.18	$32.50
☐	0067	Signature A $10 12/24/24	$11.03	$16.55	$26.67
☐	0001	Signature B $10 12/12/24	$13.75	$20.68	$33.32
☐	0068	Signature C $10 12/12/12	$16.79	$25.24	$40.65

Employer Sponsored VSP Participation Requirements: Minimum of 3 enrolled employee at all times.

The employer must choose one of the following participation options:

☐ Option 1	VSP participation and contribution matches employer-sponsored medical plan participation exactly
☐ Option 2	VSP participation and contribution matches employer-sponsored dental plan participation exactly
☐ Option 3	VSP participation is 100% employer paid and all eligible employees and all eligible dependents are enrolled
☐ Option 4	VSP participation is 100% employer paid and all eligible employees and no dependents are enrolled

Voluntary Vision Service Plan
Minimum of one enrolled employee required at all times.

Rates effective January 1, 2017 through December 31, 2017. This plan renews every January.

Choose plan option(s)	Plan #	Plan Name	Employee Only	EE + 1 or Employee + Children	EE + Family
☐	0009	Choice A $15/$30 12/24/24	$8.55	$13.34	$20.87
☐	0010	Choice B $15/$30 12/12/24	$11.36	$17.91	$28.28
☐	0025	Signature C $15/$30 12/12/12	$17.32	$27.24	$42.94

Voluntary VSP Participation Requirements: Minimum of 1 enrolled. Employer contribution can be 0% to 100%.

These VSP plans are only available to groups headquartered in one of the following states: CA, CO, GA, IA, IL, IN, KS, MI, MN, MO, NC, NJ, NV, OH, OK, SC, TN, TX, and WV. Employees can live in any State.

ALL VISION ELIGIBILITY: Eligible employees must enroll at initial enrollment, or within 30 days of a Qualifying Event. Eligible employees declining dependent coverage **cannot enroll their dependents at a later time** unless the dependents show proof of loss of prior coverage. An eligible dependent is an employee's spouse/domestic partner and any child of the enrolled applicant or spouse/domestic partner who is under age 26. It is the employee's responsibility to inform the group administrator of any change in status of his/her dependents. Dependent children may remain on this plan to age 26.

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6. Dental Coverage Selection

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.

If enrolling in a dental plan, has your group had prior dental coverage for the past twelve months? ☐ Yes ☐ No

Who is your current dental carrier?		**Date of Coverage From:**		**To:**	

☐ **Include a copy of your group's prior carrier dental invoice** to be considered to have the 12-month major service waiting period waived at initial enrollment for all enrollees. Please Note: Future new hires and dependents will be subject to the 12 month major service waiting period.

Ameritas
fulfilling life.

Voluntary Ameritas Dental.
Minimum of one enrolled employee required at all times.

Rates effective January 1, 2017 through December 31, 2017.
Available to groups headquartered in AZ, CA, NV, and UT. Employees can reside in any state.

Choose ONE Plan	Plan #	Plan Names	Employee Only	EE + 1 Dependent	EE + 2 or more Dependents
☐	Plan # 1	PPO $1,000	$33.73	$60.71	$93.54
☐	Plan # 2	PPO $1,250	$48.29	$89.40	$147.81

Voluntary *Ameritas* Dental Participation Requirements: Minimum of 1 enrolled. Employer contribution can be 0% to 100%.

DELTA DENTAL®

Voluntary Delta Dental PPO and DeltaCare HMO.
Minimum of three enrolled in each chosen plan.

Rates effective January 1, 2017 through December 31, 2017. This plan renews every January.
Available to groups headquartered in CA. Employees enrolled in PPO can reside in any state.

Choose One Plan	Plan #	Plan Names	Employee Only	EE + 1 Dependent	EE + 2 or more Dependents
☐	465 H	PPO 100/80/50 $1000 w/Ortho	$45.39	$85.39	$147.86
☐	465 G	PPO 100/80/50 $1500	$53.05	$96.83	$147.50
☐	465 J	PPO 100/80/50 $2000	$58.21	$106.38	$162.11
Choose One Plan	DeltaCare HMO Region is based on the county for the zip code of Employer's address.				
☐	71989-12A	DeltaCare HMO Region 1 & 2*	$24.99	$40.31	$58.93
☐	71989- 12A	DeltaCare HMO Region 3*	$25.59	$41.31	$60.36
☐	71989-12A	DeltaCare HMO Region 4*	$26.13	$42.22	$61.72
☐	71989-12A	DeltaCare HMO Region 5*	$50.85	$82.95	$122.02

*Region 1&2	Los Angeles and Orange counties
*Region 3	Alameda, Contra Costa, Fresno, Kern, Mariposa, Riverside, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara and Ventura
*Region 4	Alpine, Amador, Calaveras, Colusa, El Dorado, Imperial, Inyo, Kings Madera, Marin, Merced, Monterey, Napa, Nevada, Placer, Plumas, Sacramento, San Joaquin, San Luis Obispo, Santa Barbara, Sierra, Solano, Stanislaus, Tuolumne, Tulare and Yolo
*Region 5	Butte, Del Norte, Glenn, Humboldt, Lake Lassen, Mendocino, Modoc, Mono, San Benito, Santa Cruz, Shasta, Siskiyou, Sutter, Tehama, Trinity, Yuba

Voluntary *Delta Dental* Participation Requirements: Minimum of 3 enrolled. Employer contribution can be 0% to 100%.

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Humana

Voluntary Humana Dental. *Minimum of two enrolled at all times. Choose 1 or more plans.*						
Rates effective January 1, 2017 through December 31, 2017. Available to groups with 2+ employees headquartered in CA. Employees can reside in any State for PPO products. Employer contribution can be 0% to 100%.						
Choose plan option(s)	**Plan #**	**Plan Names**	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
☐	**03CA3V0614**	PPO Preventive Plus 100/80/0 $1,000 P/E/M INFS	$31.18	$67.99	$64.40	$108.27
☐	**03CA3V0586**	PPO Traditional Preferred 100/80/50 $1,500 P/E/B INFS	$60.74	$135.66	$94.30	$170.35
☐	**03CA3V0619**	PPO 100/100/60 100/80/50 Unlimited P/E/B INFS	$67.67	$155.55	$105.69	$192.92
☐	**03LD3V0002**	CA Liberty LS200 DHMO (CA residents only)	$16.18	$35.04	$29.73	$49.18

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7. Premium Calculation Worksheet (copy this page if more than one plan from each carrier is chosen)

Vision Service Plan (VSP) Employer Sponsored Vision Plan #_____

	# of Members		Rate		
Employee Only		X	$	=	$
Employee + 1 or Employee + Children		X	$	=	$
Employee + Family		X	$	=	$
			Subtotal		$

Vision Service Plan (VSP) Voluntary Vision Plan #_____

	# of Members		Rate		
Employee Only		X	$	=	$
Employee + 1 or Employee + Children		X	$	=	$
Employee + Family		X	$	=	$
			Subtotal		$

Ameritas Dental Voluntary Plan #_____

	# of Members		Rate		
Employee Only		X	$	=	$
Employee + 1 Dependent		X	$	=	$
Employee + 2 or more Dependents		X	$	=	$
			Subtotal		$

Delta Dental Voluntary *HMO* Plan #_____

	# of Members		Rate		
Employee Only		X	$	=	$
Employee + 1 Dependent		X	$	=	$
Employee + 2 or more Dependents		X	$	=	$
			Subtotal		$

Delta Dental Voluntary *PPO* Plan #_____

	# of Members		Rate		
Employee Only		X	$	=	$
Employee + 1 Dependent		X	$	=	$
Employee + 2 or more Dependents		X	$	=	$
			Subtotal		$

Humana Dental Voluntary Plan #_____

	# of Members		Rate		
Employee Only		X	$	=	$
Employee + Spouse		X	$	=	$
Employee + Child(ren)		X	$	=	$
Employee + Family		X	$	=	$
			Subtotal		$

Subtotal from all plans		$
Monthly Administration Fee	+	**$15.00**
Grand Total for Premium	=	$

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8. Employer Signature

Participation Agreement: We, the undersigned group, understand that we are applying for membership in the North Ranch Benefit Trust ("Trust"). Ameritas, Delta Dental, Humana, and Vision Service Plan ("VSP") has issued a master policy to the Trust which provides dental and/or vision benefits to employer groups and their eligible employees and dependents. We certify that all information provided with respect to the company and its employees/members is accurate and complete. If not complete, Ameritas, Delta Dental, Humana, VSP and/or HealthSmart Benefit Solutions, Inc. reserve the right to reject this application.

We, the undersigned group, understand that we have an obligation to ensure that all persons offered benefits meet eligibility requirements and that coverage is offered to every eligible person. We understand that we will be liable for any claims incurred during any period in which we do not meet the participation and eligibility maintenance requirements. We understand that VSP and/or HealthSmart Benefit Solutions, Inc. will rely on the representations contained in this document and any others, such as applications, which we provide in determining whether they will accept us as an eligible group.

It is understood that coverage for any benefits shall not commence until a completed Employer Application has been approved by Ameritas, Delta Dental, Humana, VSP, and/or HealthSmart Benefit Solutions, Inc., its authorized agents, or representatives; the first month's premium for the purchased benefit plan(s) has been paid; all completed employee applications have been submitted; and notice of said approval has been transmitted in writing. We certify that the answers on any and all applications are true and understand that coverage may be rescinded should it be determined at a future date that there are misstatements in the applications.

Some of the contracts Ameritas, Delta Dental, Humana, and VSP hold with Warner Pacific Insurance Services ("Warner Pacific") provide for payment of incentives, compensation, excess surplus and bonuses ("compensation"). In the sole and exclusive discretion of Warner Pacific, such compensation may be retained by Warner Pacific or distributed to other parties. Such compensation will not be returned to you as the employer/plan sponsor. Any benefits claims submitted under your policy/certificate will be paid without regard to such compensation.

Arbitration Agreement: We understand that any dispute between us and Ameritas, Delta Dental, Humana, VSP, Warner Pacific and/or HealthSmart Benefit Solutions, Inc. must be resolved through binding arbitration if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court and not by lawsuit or court process, except as California provides for judicial review of arbitration proceedings.

I certify that all of the information provided in this document is accurate to the best of my knowledge as of the date signed.

I also understand that the current rates are guaranteed from January 2017 through December 2017. These plans renew every January regardless of the original effective date. A $15.00 administration fee will apply to invoice each month.

Signature of Company Officer:	**X**	**Title:**	
Name (print):		**Date:**	

9. Agent Information

Agent's Certification: I hereby certify that I am not aware of any information that has been withheld from this application by the client and which may have bearing on this risk. I hereby certify that I have advised the client not to terminate any existing coverage until they have received written notification from Warner Pacific Insurance Services and/or HealthSmart Benefit Solutions, Inc. that the coverage being requested by this application is accepted. Upon first submission, the agent or agency must provide copy of current Producer License and a completed W-9.

Agent Name:				NRBT Agent ID #:	
License #:		State Issued:		Expiration (MM/YY):	
Email:					
Mailing Address:					
City:		State:		Zip Code:	
Phone:				Fax:	
Agency Name:					
Mailing Address *(if different than above)*:					
City:		State:		Zip Code:	
Agent Signature:	**X**			**Date:**	
Name (print):					