NORTH RANCH BENEFITS TRUST

Employee Application – Dental and Vision

California and other applicable states as noted on Employer Application

NORTH RANCH BENEFITS TRUST
POWERED BY WARNER PACIFIC

Employer Name:		Division #:	

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.

Change or Qualifying Event (give 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_____

CHECK YOUR PLAN SELECTION(S). OPTIONS AVAILABLE WILL BE BASED ON THE CHOICE(S) OFFERED BY YOUR EMPLOYER.

VOLUNTARY AMERITAS DENTAL	VOLUNTARY DELTA DENTAL	VOLUNTARY HUMANA DENTAL	VOLUNTARY VISION SERVICE PLAN	EMPLOYER SPONSORED VISION SERVICE PLAN
☐ Ameritas Dental	☐ Delta Premier ☐ Delta PPO ☐ Delta Care DHMO*	☐ PPO ☐ PPO Traditional Preferred ☐ PPO Preventive Plus ☐ DHMO*	☐ Vision*	☐ Vision
	*Primary Dentist:	*Primary Dentist:	*List VSP Plan Name:	
www.ameritas.com	www.deltadentalins.com	www.humana.com	www.vsp.com	www.vsp.com
☐ 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 ☐ Employee + Children ☐ Family	☐ Employee ONLY ☐ Employee + 1 ☐ Employee + Children ☐ Family

Employee Information

Dental	Vision	First Name	MI	Last Name	Gender	Relationship	DOB MMDDYYYY	Disabled
☐	☐				☐ M ☐ F	☐ SELF		N/A
☐	☐				☐ M ☐ F	☐ SPOUSE ☐ DOMESTIC PARTNER		N/A
☐	☐				☐ M ☐ F	☐ CHILD		☐ Yes ☐ No
☐	☐				☐ M ☐ F	☐ CHILD		☐ Yes ☐ No
☐	☐				☐ M ☐ F	☐ CHILD		☐ Yes ☐ No
☐	☐				☐ M ☐ F	☐ CHILD		☐ Yes ☐ No

Note: Eligible employees, and their dependents, must enroll within 30 days of the group's new hire waiting period or a Qualifying Event.

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 _____ to _____.

EMPLOYEE SIGNATURE:		**DATE:**	