Return enrollment forms to:
HealthSmart Benefit Solutions, Inc.
Phone: (800) 786-6525 Fax: (303) 804-9490
Email: NRBT@healthsmart.com

North Ranch Benefits Trust
Dental and/or Vision Employee Enrollment/Change Form

Group administrator should return completed forms to HealthSmart within 30 days of Qualifying Event. Missing information could delay processing.

Vision Service Plan: ☐ ________________________ **Print Plan Name**	Look up Providers at: www.vsp.com	Requested Effective Date (First of the month only)

Employer Information

GROUP NAME	GROUP/DIVISION #
CONTACT PERSON	TITLE
CONTACT EMAIL	CONTACT PHONE #

OUR GROUP'S WAITING PERIOD FOR NEW HIRES IS FIRST OF MONTH FOLLOWING:	☐ **Date of Hire**	☐ **1 month**	☐ **2 months**	☐ Other:

Reason for Enrollment (Qualifying Event) or Change (CHECK ONE BOX FROM THE FIRST ROW AND THEN ONE BOX FROM THE SECOND FOR COBRA STATUS)

☐ New Hire ☐ Rehire ☐ Part-time to Full-time	☐ Marriage/Domestic Partnership ☐ Divorce ☐ Birth/Adoption	☐ Loss of Other Group Coverage: please provide a letter from the carrier or employer for proof of loss	☐ Name Change ☐ Social Security correction ☐ Address Change ☐ Other ____________________________________

☐ **Our group is Federal COBRA eligible** **Federal COBRA Enrollment** Administered by Employer	☐ **Our group is State COBRA Enrollment (If applicable)** Administered by HealthSmart if member elects. Please send offer to terminated member. Y or N.

DENTAL NOTE: Eligible employees electing for themselves must enroll following completion of the groups waiting period. Employees who do not enroll **cannot enroll at later date** unless they show proof of loss of prior coverage under another dental program. Enrollees electing dependent coverage must enroll all eligible dependents. Enrollees declining dependent coverage **cannot enroll their dependents at a later time** unless the dependents show proof of loss of prior coverage.

Member Information

FIRST NAME, LAST NAME			SOCIAL SECURITY #
STREET ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	☐ **Male** ☐ **Female**	DATE OF BIRTH (MMDDYY)	DATE OF HIRE (MMDDYY)

Dependents To Be Enrolled

SPOUSE/DOMESTIC PARTNER'S FIRST NAME, LAST NAME	☐ **Male** ☐ **Female**	DATE OF BIRTH (MMDDYY)	☐ **Spouse** ☐ **Domestic Partner**
CHILD'S FIRST NAME, LAST NAME	☐ **Male** ☐ **Female**	DATE OF BIRTH (MMDDYY)	
CHILD'S FIRST NAME, LAST NAME	☐ **Male** ☐ **Female**	DATE OF BIRTH (MMDDYY)	
CHILD'S FIRST NAME, LAST NAME	☐ **Male** ☐ **Female**	DATE OF BIRTH (MMDDYY)	
CHILD'S FIRST NAME, LAST NAME	☐ **Male** ☐ **Female**	DATE OF BIRTH (MMDDYY)	

Member Signature	**Date**