NORTH RANCH BENEFITS TRUST
POWERED BY WARNER PACIFIC

HealthSmart
SMARTER HEALTHCARE SOLUTIONS

# NORTH RANCH BENEFITS TRUST
# VOLUNTARY DELTACARE HMO ENROLLMENT INSTRUCTIONS

- Three or more employees are required to be enrolled at all times.
- DeltaCare HMO is available in California only.
- **New group enrollments must be submitted to Warner Pacific before the 15th of the month prior to requested effective date.**
- Complete the Employer Application form and select ONE plan design for the entire employer group.
- **Print an employee application (Page 4) for each employee to enroll.**
- If the enrolling employee does not elect to cover their dependents, then dependents may not enroll later unless there is a qualifying event. Dependent children may remain on this plan to age 26.
- All employer groups will be made effective on the first of any given month.
- This plan has a Focal Renewal January 1 of every year.

- The first month's premium is required via check or bank draft (ACH)
  - If paying by check, make Check payable to HealthSmart Benefit Solutions, Inc.
  - Future payments by Check should be directed to the Lockbox:

    HealthSmart Benefit Solutions, Inc.
    Lock Box 6054
    P.O. Box 17768
    Denver, CO 80217-0768
    Phone: (800) 786-6525

  - If paying by Bank Draft (ACH), complete attached form.
    If changing bank accounts, we require a 30 day notification.

- Submit all completed New Business forms to Warner Pacific for processing:

    Warner Pacific Insurance Services, Inc. – New Business
    32110 Agoura Road
    Westlake Village, CA 91361-4026
    Phone : (800) 801-2300
    Fax : (800) 609-0111
    Email: CAnewbusiness@warnerpacific.com

- Once the group is approved all future new hire forms/qualifying event applications should be sent to HealthSmart directly for processing:

    HealthSmart Benefit Solutions, Inc.
    10303 E. Dry Creek Road, Suite 200
    Englewood, CO 80112
    Phone : (800) 786-6525
    Fax : (303) 804-9490
    pbdenver@healthsmart.com

**EMPLOYERS:**

Each enrolled employee must choose a Primary Care Dentist, if they do not select a dentist one will be assigned to them. Once enrolled, if they want to change Dentists they need to contact Delta directly and the provider change will be effective first of the month following request.

A Contracted Facility Name and Number can be found at www.deltadentalins.com.

# NORTH RANCH BENEFITS TRUST
# VOLUNTARY DELTACARE HMO EMPLOYER APPLICATION

| Employer Group Information | Effective Date : | |
|---|---|---|
| Group Name : | Company Tax ID: | |
| Address : | | |
| City : | State : | Zip Code : |
| Contact Person : | | |
| Phone : | Fax : | |
| Email : | | |
| What is your group's waiting period for new hires? First of the month following: ___Date of Hire ___1 month ___2 months | | |
| Is your group subject to Federal or State COBRA? ___Federal ___State ___Neither | | |

**Monthly rates effective through 12/31/14**

**Region 1 & 2 covers the following counties:**
Los Angeles & Orange

**Region 3 covers the following counties:**
Alameda, Contra Costa, Fresno, Kern, Mariposa, Riverside, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara & Ventura

**Region 4 covers the following counties:**
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, Tuolomne, Tulare & Yolo

**Region 5 covers the following counties:**
Butte, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Mono, San Benito, Santa Cruz, Shasta, Siskiyou, Sutter, Tehama, Trinity & Yuba

| Plan 12A | □ Region 1&2 | □ Region 3 | □ Region 4 | □ Region 5 |
|---|---|---|---|---|
| **Employee Only** | $ 21.52 x ____ = $ ____ | $ 22.08 x ____ = $ ____ | $ 22.58 x ____ = $ ____ | $ 45.15 x ____ = $ ____ |
| **Employee + 1 dependent** | $ 35.53 x ____ = $ ____ | $ 36.44 x ____ = $ ____ | $ 37.26 x ____ = $ ____ | $ 74.48 x ____ = $ ____ |
| **Employee + 2 or more dep's** | $ 52.54 x ____ = $ ____ | $ 53.85 x ____ = $ ____ | $ 55.09 x ____ = $ ____ | $ 110.15 x ____ = $ ____ |
| Subtotal | $ | | | |
| Monthly Admin Fee | $ 15.00 | | | |
| **Total** | $ | | | |

**Choose your billing option:** ☐ **Auto Draft (ACH)** ☐ **Monthly paper bill**

| Broker Information | North Ranch Benefit Trust ID # (WPIS): | |
|---|---|---|
| Agent Name : | License #: | |
| Agency Name : | License #: | |
| Address: | | |
| City : | State : | Zip Code : |
| Phone : | Fax : | |
| Email : | | |
| Upon first submission, the agent or agency must provide copy of current license and a completed W-9. | | |
| General Agent: | | |

# AUTHORIZATION FOR DIRECT PAYMENT

I am returning this authorization to **HealthSmart Benefit Solutions, Inc.**, authorizing HealthSmart and the financial institution named below to initiate entries to my checking/savings account. This authority will remain in effect until I notify you 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.

## Client Information

**Client Name** **Client (Division) #** **Contact Phone Number**

**Client Address** **City** **State** **Zip**

## Financial Institution Information (Please enter name/address of bank and account you wish payments to be withdrawn from.)

**Name of Bank** **Branch**

**Address of Bank** **City** **State** **Zip**

**Signature (This is your authorization for HBS to withdraw funds from your account)** **Date**

Please check one: ☐ Checking ☐ Savings
Please check: ☐ Initial Payment Only and/or ☐ Ongoing Monthly Premium Payments

***Note:*** Withdrawals from your bank account will occur on the 1st working day of each month for which the premium is due.

Bank Routing # ______________________________ Account # __________________________________

**Please return the completed form and a copy of the voided check to:**

**HEALTHSMART BENEFIT SOLUTIONS, INC.**
**10303 E DRY CREEK RD STE 200**
**ENGLEWOOD CO 80112-1583**
**or fax to (303) 804-9490.**

STAPLE VOIDED CHECK HERE

(Cut here and retain for your records)

On (date) ___________________________, I authorized HealthSmart Benefit Solutions, Inc. at 10303 East Dry Creek Road, Suite 200, Englewood, CO 80112 to initiate electronic entries to my checking/savings account and have agreed to the terms listed on the authorization. I may revoke my authorization with the company at any time by writing to HealthSmart at the address above. *If the payment amount changes, we will notify you at least 5 days before the regularly scheduled payment date.*

NRBT-HBS - Rev. 09.01.2014

# ENROLLMENT/CHANGE FORM

**FOR EMPLOYER USE ONLY**

Group No. ----------------------

Contract Type ----------------------

Effective Date ----------------------

These forms must be received at HealthSmart before the 15th of the month prior to requested effective date.

Future new hire and qualifying event forms should be sent to:
HealthSmart Benefit Solutions, Inc.
Phone: (800) 786-6525
FAX: (303) 804-9490
Email: PBDenver@healthsmart.com

## Check One

☐ New Enrollment
☐ Name Change
☐ Facility Change*
☐ COBRA
☐ New Social Security Number/ Employee ID Number
☐ Address Change
☐ Add Dependent
☐ Remove Dependent

Indicate effective date of change:
*(Does not pertain to facility change)

(Month) (Day) (Year)

## COBRA Enrollment Only

Please indicate qualifying event:

☐ Termination
☐ Divorce
☐ Widowed
☐ Surviving Dependent
☐ Overage Dependent

Indicate qualifying date:

(Month) (Day) (Year)

## Primary Enrollee Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: (Last) (First) (M.I.)

Mailing Address: (Street Address)

(City) (State) (Zip Code)

Date of Birth: (Month) (Day) (Year)

Male
Female

Home Phone #: ( ) —

Name of Employer/Group:

Location:

Soc. Security #: — —

Employee Identification #:

Contract Facility Name:

Contract Facility #:

## Dependent Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (To add additional dependents, please attach a separate sheet.) Note: You may choose up to three separate offices for yourself and all dependent enrollees

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF

| Relationship Code* | Dependent Name | Gender (Check One) M F | Date of Birth (Month) (Day) (Year) | Contract Facility Name | Contract Facility #: |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
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| | | | | | |
| | | | | | |

*Relationship Codes: Place the following two character code in the first column to designate each dependent as follows:
Spouse - SP  Domestic Partner - DP  Child - CH  Child of DP - CD  Other Adult - OA  Other Child - OC

NOTE: If the enrolling employee does not elect to cover their dependents, then dependents may not enroll later unless there is a qualifying event.

Signature of Primary Enrollee ______________________________ Date: ____________

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