NORTH RANCH BENEFITS TRUST
POWERED BY WARNER PACIFIC

HealthSmart
SMARTER HEALTHCARE SOLUTIONS

NORTH RANCH BENEFITS TRUST

EMPLOYER-SPONSORED VSP PLANS EMPLOYER APPLICATION

For Office Use:
_____

Employer Group Information		Requested Effective Date: _____/_____/_____
Group Name:		Company Tax ID:
Street Address:		
City:	State:	ZIP Code:
Billing Address (if different):		
City:	State:	ZIP Code:
Contact Person:		Contacts Email:
Phone:		Fax:
Choose one (1) participation option: # _____	1. VSP participation and contribution matches the employer-sponsored medical plan participation exactly **OR** 2. VSP participation and contribution matches the employer-sponsored dental plan participation exactly **OR** 3. VSP participation is 100% employer paid and all eligible employees and all eligible dependents are enrolled **OR** 4. VSP participation is 100% employer paid and all eligible employees and no dependents are enrolled	
I would like my bill : ____mailed ____ emailed to: _____		
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 Federal or State COBRA eligible?		
I understand that a $15 administration fee will apply to my group's bill each month.		
Participation Agreement: We, the undersigned group understand that we are applying for membership in the North Ranch Benefit Trust ("Trust"). 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, VSP and/or HealthSmart Benefit Solutions, Inc. reserve the right to reject this application.		
Signature of Company Officer:		**Title:**
Print Name:		**Date:**

Broker Information		North Ranch Benefit Trust ID # (WPIS):
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.		
Agent Name:		Agent License #:
Agency Name:		Agency 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.		

Please return to:
Warner Pacific Insurance Services ▪ 32110 Agoura Road ▪ Westlake Village, CA 91361-4026
Phone: (800) 801-2300 ▪ Fax: (800) 609-0111
Email: CANewBusiness@WarnerPacific.com

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Vision Service Plan (Employer-Sponsored)						
Rates effective January 1, 2015 through December 31, 2015. 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. Minimum of three enrolled employees required at all times.						
Check ONE plan option	**Plan #**	**Plan Name**	**Employee Only**	**EE + 1 Dependent**	**EE + Children**	**EE + Family**
Signature Plans						
	Plan # 67	Signature Plan A $10	$11.03	$16.19	$16.55	$26.67
	Plan # 66	Signature Plan A $25	$8.68	$12.93	$13.18	$21.28
	Plan # 01	Signature Enhanced B $10	$13.75	$20.27	$20.68	$33.32
	Plan # 02	Signature Enhanced B $25	$10.86	$16.16	$16.52	$26.61
	Plan # 68	Signature Plan C $10	$16.79	$24.71	$25.24	$40.65
	Plan # 69	Signature Plan C $25	$13.27	$19.76	$20.18	$32.50
Choice Plans						
	Plan # 80	Choice Plan A $0	$7.93	$12.74	$13.03	$20.97
	Plan # 81	Choice Enhanced B $0	$11.12	$16.57	$16.92	$27.28

Premium Calculation Worksheet

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

	# of Members		**Rate includes ACA Tax [1]**		
Employee Only		**X**	$	=	**$**
Employee + 1 Dependent		**X**	$	=	**$**
Employee + Children		**X**	$	=	**$**
Employee + Family		**X**	$	=	**$**
			Subtotal		**$**
			Monthly Administration Fee	+	**$15.00**
			Grand Total for Premium	=	**$**

[1] Visit www.irs.gov and search Affordable Care Act (ACA) Tax Provisions for more information.