NORTH RANCH BENEFITS TRUST

Employer Application – Vision

Colorado and other applicable States as noted on page 2

NORTH RANCH BENEFITS TRUST
POWERED BY WARNER PACIFIC

Employer Name:		Division #:	

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

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.

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

This is a prepaid plan, therefore, 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.

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, Lockbox 6054, Denver, CO 80217-0768.

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

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CHOOSE VISION COVERAGE

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

Rates effective January 1, 2016 through December 31, 2016. This plan renews every January.
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.

Check plan option(s)	Plan #	Plan Name	Employee Only	EE + 1 Dependent	EE + Children	EE + Family
		Signature Plans	If elected, minimum of 3 employee's required			
☐	0004	Signature Plan A $10	$11.03	$16.19	$16.55	$26.67
☐	0003	Signature Plan A $25	$8.68	$12.93	$13.18	$21.28
☐	0001	Signature Enhanced B $10	$13.75	$20.27	$20.68	$33.32
☐	0002	Signature Enhanced B $25	$10.86	$16.16	$16.52	$26.61
☐	0068	Signature Plan C $10	$16.79	$24.71	$25.24	$40.65
☐	0069	Signature Plan C $25	$13.27	$19.76	$20.18	$32.50
		Choice Plans	If elected, minimum of 3 employee's required			
☐	0080	Choice Plan A $0	$7.93	$12.74	$13.03	$20.97
☐	0081	Choice Enhanced B $0	$11.12	$16.57	$16.92	$27.28

Employer Sponsored VSP Participation Requirements

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 January1, 2016 through December 31, 2016. This plan renews every January.
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.

Check plan option(s)	Plan #	Plan Name	Employee Only	EE + 1 Dependent	EE + Children	EE + Family
		Signature Plans	If elected, minimum of 1 employee required			
☐	0001	Signature Exam Plus	$3.18	$6.37	$6.37	$6.38
☐	0003	Signature A $15/$30	$9.53	$14.64	$14.93	$23.43
☐	0004	Signature B $15	$17.82	$27.89	$28.45	$45.25
☐	0005	Signature B $15/$30	$12.71	$19.71	$20.11	$31.79
☐	0006	Signature A $15/$30 CVC	$13.84	$18.96	$19.24	$27.75
☐	0007	Signature B $15/$30 CVC	$17.02	$24.02	$24.42	$36.09
☐	0008	Signature B $15 CVC	$22.13	$32.20	$32.76	$49.56
		Choice Plans	If elected, minimum of 1 employee required			
☐	0009	Choice A $15/$30	$8.28	$12.65	$12.89	$20.13
☐	0010	Choice B $15/$30	$10.99	$17.12	$17.30	$27.27
☐	0011	Choice C $15	$19.54	$30.68	$31.32	$49.90

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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 Dependent		X	$	=	$
Employee + Children		X	$	=	$
Employee + Family		X	$	=	$
			Subtotal		$

Vision Service Plan (VSP) Voluntary Vision Plan # _____

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

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

DENTAL/VISION NOTE: 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.

ACH Payment Authorization

Ongoing Payment: If you elected Auto Pay (on page 1) for your initial and ongoing monthly premiums, please complete the following information.

Bank Account Information (Checking only):

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

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:		**Title:**	
Name (print):		**Date:**	

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Employer Name:		Division #:	

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 VSP and/or HealthSmart Benefit Solutions, Inc., its authorized agents, or representatives; the first month's premium for the vision benefit plan has been paid; all completed employee applications have been submitted; and notice of said approval has been transmitted in writing to us. 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 Vision Service Plan holds 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 vision 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 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 2016 through December 2016. 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:		**Title:**	
Name (print):		**Date:**	

Agent Information

North Ranch Benefit Trust Agent ID #:

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:					
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:	
Signature:				Date (MMDDYY):	