# NORTH RANCH BENEFITS TRUST
# INDIVIDUAL AND FAMILY APPLICATION - AMERITAS

For Office Use:
_____

| **Individual and Family Information** | Requested Effective Date: _____/_____/_____ | |
|---|---|---|
| Name: | | |
| Street Address: | | |
| City: | State: | ZIP Code: |
| Billing Address (if different): | | |
| City: | State: | ZIP Code: |
| Contact Person: | Contacts Email: | |
| Phone: | Fax: | |
| I would like my bill : ____mailed ____ emailed to: _____ | | |
| If enrolling in a Dental plan, did you have prior dental coverage? If so, how long? _____What carrier? _____ | | |
| I understand that a $5 administration fee will apply to my bill each month. | | |
| **Participation Agreement:** We, the undersigned group understand that we are applying for membership in the North Ranch Benefit Trust ("Trust"). Ameritas, Delta Dental, 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, VSP and/or HealthSmart Benefit Solutions, Inc. reserve the right to reject this application. | | |
| **Signature:** | | |
| **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

NORTH RANCH BENEFITS TRUST
POWERED BY WARNER PACIFIC

HealthSmart
SMARTER HEALTHCARE SOLUTIONS

| Ameritas Dental (Voluntary) | | | | | |
|---|---|---|---|---|---|
| Rates effective June 1, 2014 through December 31, 2015.<br>Available in AZ, CA, NV, and UT. | | | | | |
| **Check plan option** | **Ameritas PPO Plan #** | **Plan Names** | **Member Only** | **Member + 1 Dependent** | **Member + 2 or more Dependents** |
| Choose One | | | | | |
| | Plan # 1 | $1,000 | $28.28 | $51.88 | $80.60 |
| | Plan # 2 | $1,250 | $41.00 | $76.96 | $128.08 |

I understand that a $5 administration fee will apply to my bill each month.

Look up Providers at:
www.ameritasgroup.com

| **Member Information** | | | |
|---|---|---|---|
| FIRST NAME, LAST NAME | | SOCIAL SECURITY # | |
| STREET ADDRESS | CITY | STATE | ZIP CODE |
| PHONE NUMBER | ☐ **Male**<br>☐ **Female** | DATE OF BIRTH (MMDDYY) | |

| **Dependents To Be Enrolled** | | | |
|---|---|---|---|
| SPOUSE/DOMESTIC PARTNER'S FIRST NAME, LAST NAME | ☐ **Male**<br>☐ **Female** | DATE OF BIRTH (MMDDYY) | ☐ **Spouse**<br>☐ **Domestic Partner** |
| CHILD'S FIRST NAME, LAST NAME | ☐ **Male**<br>☐ **Female** | DATE OF BIRTH (MMDDYY) | |
| CHILD'S FIRST NAME, LAST NAME | ☐ **Male**<br>☐ **Female** | DATE OF BIRTH (MMDDYY) | |
| CHILD'S FIRST NAME, LAST NAME | ☐ **Male**<br>☐ **Female** | DATE OF BIRTH (MMDDYY) | |
| CHILD'S FIRST NAME, LAST NAME | ☐ **Male**<br>☐ **Female** | DATE OF BIRTH (MMDDYY) | |