NORTH RANCH BENEFITS TRUST

Individual/Family Application – Dental and Vision

Member Name:		For office use :	

1. Member Information					Requested Effective Date: _____/_____/_____
First Name:			Last Name:		
Social Security # :					
Mailing Address:					
City:		State:		ZIP Code:	
Billing Address (if different):					
City:		State:		ZIP Code:	
Contact Email :					
Phone:					
What is your communication preference? ☐ Mail ☐ Email					

2. Member & Dependent Information **(list all members to be enrolled)**

Vision	Dental	First Name	MI	Last Name	Gender	Relationship	DOB (MM/DD/YYYY)
☐	☐				☐ M ☐ F	☐SELF	
☐	☐				☐ M ☐ F	☐ SPOUSE ☐ DOMESTIC PARTNER	
☐	☐				☐ M ☐ F	☐ CHILD	
☐	☐				☐ M ☐ F	☐ CHILD	
☐	☐				☐ M ☐ F	☐ CHILD	
☐	☐				☐ M ☐ F	☐ CHILD	

Eligibility Note: Primary applicant and their dependent(s) must enroll at initial enrollment to be eligible for coverage. Dependents who waive coverage must have a qualifying event or wait until open enrollment to come on at a later date. An eligible dependent(s) declining coverage cannot enroll at a later date unless the dependent(s) can show proof of loss of prior coverage. An eligible dependent(s) is an individual's spouse/domestic partner, and any child of the enrolled applicant or spouse/domestic partner, who is under age 26. Dependent children may remain on this plan to age 26. If an enrolled member would like to enroll their dependents, the dependent must have a qualifying event or wait until open enrollment.

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3. Invoice and Payment Preferences	
Invoices:	☐ Mailed *and/or* ☐ Emailed (Email to: _____ or ☐ Same email as above)
Initial Payment Mode:	☐ Check ☐ ACH Draft (complete section 4)
Ongoing Payment Mode:	☐ Check paid monthly – due by the 1st business day of each month ☐ ACH Draft paid monthly – Drafted on the 1st business day (complete section 4)
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, Denver, CO 80217-0768. **Ongoing Payment:** This is a prepaid plan and 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.	
Monthly Administration Fee:	**$5.00 administration fee will apply to invoice each month.**

4. ACH Payment Authorization	
Account Holder's Name	
Name of Bank	
Bank Address	
Bank Routing Number	
Account Number	
☐ **Please attach a voided check**	
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 Account Holder:	**X**

Name (print):		**Date:**	

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5. Vision Coverage Selection

Voluntary Vision Service Plan

Minimum of one enrolled employee required at all times.

Rates effective January 1, 2017 through December 31, 2017. This plan renews every January.

Choose plan option(s)	Plan #	Plan Name	Employee Only	EE + 1 or Employee + Children	EE + Family
☐	0009	Choice A $15/$30 12/24/24	$8.55	$13.34	$20.87
☐	0010	Choice B $15/$30 12/12/24	$11.36	$17.91	$28.28
☐	0008	Signature C $15/$30 12/12/12	$17.32	$27.24	$42.94

Voluntary VSP Participation Requirements: Minimum of 1 enrolled. Employer contribution can be 0% to 100%.

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.

ALL VISION ELIGIBILITY: 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.

6. Dental Coverage Selection

Waiving Dental Waiting Periods

Ameritas Dental plans have a 12 month major service waiting period for services. This may waived if proof of 12 months of continuous prior coverage is included with this application. Please provide a copy of your prior carrier dental ID card or invoice with this application.

If enrolling in a dental plan, have you had prior dental coverage for the past twelve months? ☐ Yes ☐ No

Who is your current dental carrier?		Date of Coverage From:		To:	

☐ **Include a copy of your prior carrier dental ID card or invoice** to be considered to have the 12-month major service waiting period waived at initial enrollment for all enrollees. Please Note: Future new hires and dependents will be subject to the 12 month major service waiting period.

Voluntary Ameritas Dental

Rates effective January 1, 2017 through December 31, 2017.

Available to groups headquartered in AZ, CA, NV, and UT. Employees can reside in any state.

Choose ONE Plan	Plan #	Plan Names	Employee Only	EE + 1 Dependent	EE + 2 or more Dependents
Ameritas PPO					
☐	Plan # 1	$1,000	$33.73	$60.71	$93.54
☐	Plan # 2	$1,250	$48.29	$89.40	$147.81

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7. Premium Calculation Worksheet (copy this page if more than one plan from each carrier is chosen)

Vision Service Plan (VSP) Voluntary Vision Plan # _____

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

Ameritas Dental Voluntary Plan # _____

	# of Members		Rate		
Employee Only		X	$	=	$
Employee + 1 Dependent		X	$	=	$
Employee + 2 or more Dependents		X	$	=	$
			Subtotal		$

Subtotal from all plans		$
Monthly Administration Fee	+	$ 5.00
Grand Total for Premium	=	$

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POWERED BY WARNER PACIFIC

Member Name:		For office use :	

8. Signature

Participation Agreement: We, the undersigned, understand that we are applying for membership in the North Ranch Benefit Trust ("Trust"). Ameritas 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, Vision Service Plan ("VSP") and/or HealthSmart Benefit Solutions, Inc. reserve the right to reject this application.

We, the undersigned member, 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 Ameritas, Delta Dental, Humana, 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 Application has been approved by Ameritas, Delta Dental, Humana, 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 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 that Ameritas and Vision Service Plan ("VSP") hold 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 2017 through December 2017. These plans renew every January regardless of the original effective date. A $5.00 administration fee will apply to invoice each month. And that I am at least 18 years of age.

Signature of Primary Member:	**X**		
Name (print):		**Date:**	

9. Agent Information

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:				NRBT Agent ID #:	
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:	
Agent Signature:	**X**			**Date (MM/DD/YY):**	
Name (print):					