NORTH RANCH BENEFITS TRUST

Individual/Family Application – Dental and Vision

California and other applicable States as noted on page 2

NORTH RANCH BENEFITS TRUST
POWERED BY WARNER PACIFIC

Member Name:		For office use :	

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					

DEPENDENT INFORMATION (list all members to be enrolled)

Vision	Dental	First Name	MI	Last Name	Gender	Relationship	DOB (MMDDYYYY)	Disabled
▣	▣				⊡ M ⊡ F	SELF		N/A
▣	▣				⊡ M ⊡ F	⊡ SPOUSE ⊡ DOMESTIC PARTNER		N/A
▣	▣				⊡ M ⊡ F	⊡ CHILD		⊡ Yes ⊡ No
▣	▣				⊡ M ⊡ F	⊡ CHILD		⊡ Yes ⊡ No
▣	▣				⊡ M ⊡ F	⊡ CHILD		⊡ Yes ⊡ No
▣	▣				⊡ M ⊡ F	⊡ CHILD		⊡ Yes ⊡ No

DENTAL/VISION NOTE: Eligible members and their dependents must enroll at initial enrollment, or within 30 days of a Qualifying Event. Eligible dependents declining coverage **cannot enroll 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. Dependent children may remain on this plan to age 26.

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:	**$5.00 administration fee will apply to invoice each month.**

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Member Name:		For office use :	

CHOOSE VISION COVERAGE

Voluntary Vision Service Plan

Rates effective January 1, 2016 through December 31, 2016. **This plan renews every January.**
These VSP plans are only available to residents 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. Members can access services in any of the 50 states.

Check plan option	Plan #	Plan Name	Member Only	Member + 1 Dependent	Member + Children	Family
		Signature Plans				
▣	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				
▣	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

CHOOSE DENTAL COVERAGE

Voluntary Ameritas Dental

Rates effective January 1, 2016 through December 31, 2016.
Available to groups headquartered in AZ, CA, NV, and UT. Employees can reside in any state.

Check plan option	Plan #	Plan Names	Member Only	Member + 1 Dependent	Member + 2 or more Dependents
		Ameritas PPO			
▣	Plan # 1	$1,000	$32.49	$58.42	$89.98
▣	Plan # 2	$1,250	$46.47	$85.99	$142.16

Have you had prior dental coverage for the past twelve months? ▣ Yes ▣ No
Prior Dental Carrier(s) for past 12 months: _____ Dates: from _____ to _____

Include a copy of your prior carrier dental invoice to be considered to have the 12-month major service waiting period waived at initial enrollment for all enrollees. Future dependents will be subject to the 12 month major service waiting period.

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

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Member Name:		For office use :	

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:**	

Signature

Participation Agreement: We, the undersigned, 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 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 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 $5.00 administration fee will apply to invoice each month.

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

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Member Name:		For office use :	

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):			