NORTH RANCH BENEFITS TRUST
VOLUNTARY VSP CHOICE PLANS ENROLLMENT INSTRUCTIONS

- One or more employees are required to be enrolled at all times.
- Complete the Employer Application form and select ONE plan design for the entire employer group; or
  If offering multiple plans, each employee must select a plan design on their application form.
- **Print an employee application (Page 4) for each employee to enroll.**
- If the enrolling employee does not elect to cover their dependents, then dependents may not enroll later unless there is a qualifying event. Dependent children may remain on this plan to age 26.
- All employer groups will be made effective on the first of any given month.
- This plan has a Focal Renewal March 1 of every year.

- The first month's premium is required via check or bank draft (ACH)
  - If paying by check, make Check payable to HealthSmart Benefit Solutions, Inc.
  - Future payments by Check should be directed to the Lockbox:

    HealthSmart Benefit Solutions, Inc.
    Lock Box 6054
    P.O. Box 17768
    Denver, CO 80217-0768
    Phone: (800)786-6525

  - If paying by Bank Draft (ACH), complete attached form
    If changing bank accounts, we require a 30 day notification.

- Submit all completed New Business forms to Warner Pacific for processing:

  Warner Pacific Insurance Services, Inc. – New Business
  32110 Agoura Road
  Westlake Village, CA 91361-4026
  Phone: (800) 801-2300
  Fax: (800) 609-0111
  Email: CAnewbusiness@warnerpacific.com

- Once the group is approved all future new hire forms/qualifying event applications should be sent to HealthSmart directly for processing:

  HealthSmart Benefit Solutions, Inc.
  10303 E. Dry Creek Road, Suite 200
  Englewood, CO 80112
  Phone: (800) 786-6525
  Fax: (303) 804-9490
  Email: pbdenver@healthsmart.com

NORTH RANCH BENEFITS TRUST
VOLUNTARY VSP CHOICE PLANS EMPLOYER APPLICATION

Employer Group Information	Requested Effective Date : _____/__1__/_____	
Group Name :	Company Tax ID:	
Address :		
City :	State :	Zip Code :
Contact Person :		
Phone :	Fax :	
Email :		
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 subject to Federal or State COBRA? ___Federal ___State ___Neither		

Monthly Rates Effective through 2/28/2015			
Choose one or more Plans that your company will offer	☐ **Choice Plans A $15/$30 12/24/24** **$15 Exam copay/$30 Materials copay $150 Frame allowance**	☐ **Choice Plans B $15/$30 12/12/24** **$15 Exam copay/$30 Materials copay $150 Frame allowance**	☐ **Choice Plans C $15 12/12/12** **$15 Exam/Material copay $150 Frame allowance**
Employee Only	$ 7.82 x _____= $_____	$ 10.36 x _____= $_____	$ 18.37 x _____= $_____
Employee + Spouse	$ 11.91 x _____= $_____	$ 16.10 x _____= $_____	$ 28.81 x _____= $_____
Employee + Child(ren)	$ 12.13 x _____= $_____	$ 16.27 x _____= $_____	$ 29.41 x _____= $_____
Employee + Family	$ 18.91 x _____= $_____	$ 25.60 x _____= $_____	$ 46.82 x _____= $_____
Subtotal			
Monthly Admin Fee	$15.00		
Total			
Choose your billing option: ☐ Auto Draft (ACH) ☐ Monthly Paper Bill			

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

AUTHORIZATION FOR DIRECT PAYMENT

I am returning this authorization to **HealthSmart Benefit Solutions, Inc.**, authorizing HealthSmart and the financial institution named below to initiate entries to my checking/savings account. This authority will remain in effect until I notify you 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.

Client Information

Client Name | **Client (Division) #** | **Contact Phone Number**

Client Address | **City** | **State** | **Zip**

Financial Institution Information (Please enter name/address of bank and account you wish payments to be withdrawn from.)

Name of Bank | **Branch**

Address of Bank | **City** | **State** | **Zip**

Signature (This is your authorization for HBS to withdraw funds from your account) | **Date**

Please check one: ☐ Checking ☐ Savings
Please check: ☐ Initial Payment Only and/or ☐ Ongoing Monthly Premium Payments
Note: Withdrawals from your bank account will occur on the 1st working day of each month for which the premium is due.

Bank Routing # _____ Account # _____

Please return the completed form and a copy of the voided check to:

HEALTHSMART BENEFIT SOLUTIONS, INC.
10303 E DRY CREEK RD STE 200
ENGLEWOOD CO 80112-1583
or fax to (303) 804-9490.

STAPLE VOIDED CHECK HERE

(Cut here and retain for your records)

On (date) _____, I authorized HealthSmart Benefit Solutions, Inc. at 10303 East Dry Creek Road, Suite 200, Englewood, CO 80112 to initiate electronic entries to my checking/savings account and have agreed to the terms listed on the authorization. I may revoke my authorization with the company at any time by writing to HealthSmart at the address above. *If the payment amount changes, we will notify you at least 5 days before the regularly scheduled payment date.*

NRBT-HSB - Rev. 08.01.2014

VOLUNTARY VSP CHOICE PLANS EMPLOYEE APPLICATION

Group Name:

Choose One Plan:	☐ **Choice Plans A $15/$30 12/24/24** $15 Exam copay/$30 Materials copay $150 Frame allowance	☐ **Choice Plans B $15/$30 12/12/24** $15 Exam copay/$30 Materials copay $150 Frame allowance	☐ **Choice Plans C $15 12/12/12** $15 Exam/Material copay $150 Frame allowance

Select Coverage : _____Member Only _____Member + Spouse _____Member + Child(ren) _____Family

Employee Information

SS # :	Date of Birth :	Gender: Male Female
Last Name :	First Name :	M. I. :
Address :		
City :	State :	Zip Code :
Marital Status : _____Single _____Married _____Divorced _____Widowed		

_____Spouse _____Domestic Partner	Last Name : Gender: Male Female	First Name : Date of Birth :
Child # 1	Last Name : Gender: Male Female	First Name : Date of Birth :
Child # 2	Last Name : Gender: Male Female	First Name : Date of Birth :
Child # 3	Last Name : Gender: Male Female	First Name : Date of Birth :
Child # 4	Last Name : Gender: Male Female	First Name : Date of Birth :

Check here ☐ if additional family members sheet is attached with this application.

X

Applicant Signature **Date**

For Future New Hires:
Please send completed form to HealthSmart Benefit Solutions, Inc. within 30 days of Qualifying Event.

Changes or additions will be effective 1st of the month following receipt and/or after groups waiting period.

NRBT Administered By:
HealthSmart Benefit Solutions, Inc.
10303 E. Dry Creek Road, Suite 200
Englewood, CO 80112
Phone: 800.786.6525
Fax: 303.804.9490
pbdenver@healthsmart.com