NORTH RANCH BENEFITS TRUST
INDIVIDUAL AND FAMILY APPLICATION - VSP

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: _____		
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

Vision Service Plan (Voluntary)

Rates effective March 1, 2014 through December 31, 2015.
These VSP plans are only available 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.

Check One plan option	Plan #	Plan Name	Member Only	Member + 1 Dependent	Member + Children	Member + Family
Signature Plans						
☐	0001	Signature Exam Plus	$3.07	$6.14	$6.14	$6.14
☐	0003	Signature A $15/$30	$8.96	$13.73	$14.00	$21.93
☐	0004	Signature B $15	$16.70	$26.10	$26.62	$42.30
☐	0005	Signature B $15/$30	$11.93	$18.46	$18.83	$29.73
☐	0006	Signature A $15/$30 CVC	$13.06	$17.83	$18.09	$26.03
☐	0007	Signature B $15/$30 CVC	$16.03	$22.56	$22.93	$33.82
☐	0008	Signature B $15 CVC	$20.80	$30.20	$30.72	$46.40
Choice Plans						
☐	0009	Choice A $15/$30	$7.82	$11.91	$12.13	$18.91
☐	0010	Choice B $15/$30	$10.36	$16.10	$16.27	$25.60
☐	0011	Choice C $15	$18.37	$28.81	$29.41	$46.82

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

Look up Providers at:
www.vsp.com

Member Information

FIRST NAME, LAST NAME		SOCIAL SECURITY #	
STREET ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	☐ Male ☐ Female	DATE OF BIRTH (MMDDYY)	

Dependents To Be Enrolled

SPOUSE/DOMESTIC PARTNER'S FIRST NAME, LAST NAME	☐ Male ☐ Female	DATE OF BIRTH (MMDDYY)	☐ Spouse ☐ Domestic Partner
CHILD'S FIRST NAME, LAST NAME	☐ Male ☐ Female	DATE OF BIRTH (MMDDYY)	
CHILD'S FIRST NAME, LAST NAME	☐ Male ☐ Female	DATE OF BIRTH (MMDDYY)	
CHILD'S FIRST NAME, LAST NAME	☐ Male ☐ Female	DATE OF BIRTH (MMDDYY)	
CHILD'S FIRST NAME, LAST NAME	☐ Male ☐ Female	DATE OF BIRTH (MMDDYY)	