NORTH RANCH BENEFITS TRUST

UNIVERSAL EMPLOYER APPLICATION - VOLUNTARY PLANS

For Office Use:
_____

Employer Group Information		Requested Effective Date: _____/_____/_____
Group Name:		Company Tax ID:
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: _____		
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 Federal or State COBRA eligible?		
If enrolling in a Dental plan, has your group had prior dental coverage? If so, how long? _____What carrier? _____		
If enrolling in dental please provide your company's 4 digit SIC code_____		
I understand that a $15 administration fee will apply to my group's bill each month.		
Participation Agreement: We, the undersigned group understand that we are applying for membership in the North Ranch Benefit Trust ("Trust"). Ameritas Dental, Delta Dental, Humana 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 Dental, Delta Dental, Humana Dental, VSP and/or HealthSmart Benefit Solutions, Inc. reserve the right to reject this application.		
Signature of Company Officer:		**Title:**
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

Vision Service Plan (Voluntary)						
Rates effective March 1, 2014 through December 31, 2015. 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.						
Check plan option(s)	**Plan #**	**Plan Name**	**Employee Only**	**EE + 1 Dependent**	**EE + Children**	**EE + Family**
		Signature Plans	If elected, minimum of 1 employee required			
	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	If elected, minimum of 1 employee required			
	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

Delta Dental Premier, PPO, and DeltaCare HMO (Voluntary)					
Rates effective January 1, 2015 through December 31, 2015. Available to groups headquartered in CA. Employees enrolled in Premier or PPO can reside in any state. The DeltaCare HMO can be dual optioned with one Premier or one PPO plan but not both.					
Check plan option(s)	**Plan #**	**Plan Names**	**Employee Only**	**EE + 1 Dependent**	**EE + 2 or more Dependents**
Choose One		**Delta Dental Premier**	If elected, minimum of 3 employees required		
	464 A	80/80/80 $1000	$57.18	$105.48	$164.50
	464 C	100/80/50 $1000	$63.98	$118.85	$192.53
	464 D	80/80/50 $1500	$71.15	$129.57	$195.67
	464 E	100/80/50 $1500	$78.82	$144.55	$226.30
		Delta Dental PPO	If elected, minimum of 3 employees required		
	465 F	100/80/50 $1000	$43.98	$81.00	$127.21
	465 G	100/80/50 $1500	$53.05	$96.83	$147.50
	465 H	100/80/50 $1000 w/Ortho	$45.39	$85.39	$147.86
	465 J	100/80/50 $2000	$58.21	$106.38	$162.11
Choose One		**DeltaCare HMO**	If elected, minimum of 3 employees required		
	71989-12A	Region 1&2*	$22.94	$36.93	$53.94
	71989- 2A	Region 3*	$23.49	$37.94	$55.26
	71989-12A	Region 4*	$23.98	$38.68	$56.49
	71989-12A	Region 5*	$46.56	$75.87	$111.56
	HMO Region is based on the county for the zip code of Employer's address.				
*Region 1&2	Los Angeles and Orange counties				
*Region 3	Alameda, Contra Costa, Fresno, Kern, Mariposa, Riverside, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara and Ventura				
*Region 4	Alpine, Amador, Calaveras, Colusa, El Dorado, Imperial, Inyo, Kings Madera, Marin, Merced, Monterey, Napa, Nevada, Placer, Plumas, Sacramento, San Joaquin, San Luis Obispo, Santa Barbara, Sierra, Solano, Stanislaus, Tuolumne, Tulare and Yolo				
*Region 5	Butte, Del Norte, Glenn, Humboldt, Lake Lassen, Mendocino, Modoc, Mono, San Benito, Santa Cruz, Shasta, Siskiyou, Sutter, Tehama, Trinity,				

Ameritas Dental (Voluntary)					
Rates effective June 1, 2014 through December 31, 2015. Available to groups headquartered in AZ, CA, NV, and UT. Employees can reside in any State.					
Check plan option	**Plan #**	**Plan Names**	**Employee Only**	**EE + 1 Dependent**	**EE + 2 or more Dependents**
Choose		**Ameritas PPO**		If elected, minimum of 1 employee	
	Plan # 1	$1,000	$28.28	$51.88	$80.60
	Plan # 2	$1,250	$41.00	$76.96	$128.08

Humana Dental (Voluntary)						
Rates effective June 1, 2015 through December 31, 2016. Available to groups with 2+ employees headquartered in CA. Employees can reside in any State for PPO products.						
Check plan option(s)	**Plan #**	**Plan Names**	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
Choose any	If elected, minimum of 2 employees					
	03CA3V0282	PPO 09 100/100/60 100/80/50 $2,500 P/E/B MAF	$67.67	$155.55	$105.69	$192.92
	03CA3V0323	PPO Traditional Preferred 100/80/50 $1,500 P/E/B MAF	$60.74	$135.66	$94.30	$170.35
	03CA3V0298	PPO Preventive Plus 09 100/80/0 $1,000 P/E/M MAF	$31.18	$67.99	$64.40	$108.27
	03LD3V0002	CA Liberty LS200 DHMO (CA residents only)	$15.82	$34.22	$29.05	$48.02

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 Dependent		**X**	$	=	**$**
Employee + Children		**X**	$	=	**$**
Employee + Family		**X**	$	=	**$**
			Subtotal		**$**

Delta Dental Voluntary Plan # _____

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

Ameritas Dental Voluntary Plan # _____

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

Humana Dental Voluntary Plan # _____

	# of Members		Rate		
Employee Only		**X**	$	=	**$**
Employee + Spouse		**X**	$	=	**$**
Employee + Child(ren)		**X**	$	=	**$**
Employee + Family		**X**	$	=	**$**
			Subtotal		**$**

Subtotal from all plans		**$**
Monthly Administration Fee	+	**$15.00**
Grand Total for Premium	=	**$**