North Ranch Benefits Trust
Dental and/or Vision Employee Application for Initial Enrollment

Please use this form for the initial enrollment only. There is a separate form to add new hires or change status.

CHECK OFF YOUR PLAN SELECTIONS BELOW BASED ON THE CHOICES OFFERED BY YOUR EMPLOYER	Look up Providers at:
Vision Service Plan: ☐ _____ **Print Plan Name** **Ameritas Dental:** ☐ PPO **Delta Dental:** ☐ Premier ☐ PPO ☐ HMO - D e l t a C a r e	www.vsp.com www.ameritasgroup.com www.deltadentalins.com

DeltaCare HMO Enrollment Only (choose dentist office)

DENTAL OFFICE NAME	DENTAL OFFICE CITY	DENTAL OFFICE ID#

Employer Information

GROUP NAME

DENTAL NOTE: Eligible employees electing for themselves must enroll following completion of the groups waiting period. Employees who do not enroll **cannot enroll at later date** unless they show proof of loss of prior coverage under another dental program. Enrollees electing dependent coverage must enroll all eligible dependents. Enrollees declining dependent coverage **cannot enroll their dependents at a later time** unless the dependents show proof of loss of prior coverage.

Member Information

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

Member Signature	Date