North Ranch Benefits Trust
POWERED BY WARNER PACIFIC

Look up Providers at:
www.ameritasgroup.com
www.deltadentalins.com
www.humana.com
www.vsp.com

HealthSmart

Return form to:
HealthSmart Benefit Solutions, Inc.
Phone: (800) 786-6525 Fax: (303) 804-9490
Email: NRBT@healthsmart.com

Universal Employee Application for Voluntary Dental and/or Vision

Employer Group Name:	**Group #:**

TYPE OF ENROLLMENT (choose one):

☐ New Group ☐ New Hire ☐ Open Enrollment (Anniversary) ☐ Rehire ☐ Part-time to Full-time ☐ Marriage/Domestic Partnership ☐ Divorce ☐ Birth/Adoption

☐ Name Change ☐ Social Security Number correction ☐ Address Change ☐ Loss of Other Group Coverage: please provide a letter from the carrier or employer for proof of loss

Choose one	☐ **Our group is Federal COBRA eligible Federal COBRA Enrollment** Administered by Employer	***or***	☐ **Our group is State COBRA Enrollment (If applicable)** Administered by HealthSmart if member elects. Please send offer to terminated member. Yes ☐ or No ☐.

Member has current dental coverage from _____ to _____. Please provide a copy of your dental ID card with this application.

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.

CHECK OFF YOUR PLAN SELECTIONS BELOW BASED ON THE CHOICES OFFERED BY YOUR EMPLOYER

Ameritas	☐ Dental PPO Plan 1 - $1000		☐ Dental PPO Plan 2 - $1250	
DELTA DENTAL	☐ Dental Premier #464 A	☐ Dental Premier #464 C	☐ Dental Premier #464 D	☐ Dental Premier #464 E
	☐ Dental PPO #465 F	☐ Dental PPO #465 G	☐ Dental PPO #465 H	☐ Dental PPO #465 J
	☐ DeltaCare HMO #71989-12A (CHOOSE DENTIST OFFICE): _____ ID#: _____			
Humana	☐ DENTAL PPO 09 100/100/60 100/80/50 $2,500 P/E/B MAF – Plan #03CA3V0282			
	☐ Dental PPO Traditional Preferred 100/80/50 $1,500 P/E/B MAF – Plan #03CA3V0323			
	☐ Dental Preventive Plus 09 100/80/0 $1,000 P/E/M MAF – Plan #03CA3V0298			
	☐ Dental HMO LS200 - PLAN #03LD3V0002 (CHOOSE DENTIST OFFICE): _____ ID#: _____			
VSP Vision care for life	☐ Choice Plan A $15/$30 12/24/24	☐ Choice Plan B $15/$30 12/12/24	☐ Choice Plan C $15 12/12/12	☐ Signature Plan A $15/$30 12/24/24	☐ Signature Plan A $15/$30 CVC 12/24/24
	☐ Signature Plan B $15/$30 12/12/24	☐ Signature Plan B $15/$30 CVC 12/12/24	☐ Signature Plan B $15 12/12/24	☐ Signature Plan B $15 CVC 12/12/24	☐ Exam Plus – 12/0/0

Enrollee Information

Member ☐ Dental ☐ Vision	LAST NAME:	FIRST NAME:	M.I.:
	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH (MM/DD/YY):	
	SOCIAL SECURITY #:	PHONE NUMBER:	
	STREET ADDRESS:		
	CITY:	STATE:	ZIP CODE:
Spouse/Domestic Partner ☐ Dental ☐ Vision	LAST NAME:	FIRST NAME:	M.I.:
	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH (MM/DD/YY):	
Child #1 ☐ Dental ☐ Vision	LAST NAME:	FIRST NAME:	M.I.:
	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH (MM/DD/YY):	
Child #2 ☐ Dental ☐ Vision	LAST NAME:	FIRST NAME:	M.I.:
	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH (MM/DD/YY):	
Child #3 ☐ Dental ☐ Vision	LAST NAME:	FIRST NAME:	M.I.:
	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH (MM/DD/YY):	
Child #4 ☐ Dental ☐ Vision	LAST NAME:	FIRST NAME:	M.I.:
	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH (MM/DD/YY):	

Member Signature	**Date**