Inshore Benefits

Individual/Family Application — Dental & Vision

Member Name:	For Office Use:

1. MEMBER INFORMATION		Requested Effective Date:
First Name:	Last Name:	
Social Security #:	What is your communication preference? ☐ Mail ☐ Email	
Mailing Address:		
City:	State:	Zip Code:
Billing Address (if different):		
City:	State:	Zip Code:
Contact Email:		
Primary Phone:	Cell Phone:	

Your email address will not be used for any purpose other than communications from Inshore Benefits Trust.

2. MEMBER & DEPENDENT INFORMATION (List all members to be enrolled)

Dental	Vision	First Name	MI	Last Name	Gender	Relationship	DOB MM/DD/YYYY
☐	☐				☐ M ☐ F	☐ Self	
☐	☐				☐ M ☐ F	☐ Spouse ☐ DP	
☐	☐				☐ M ☐ F	☐ Child ☐ Disabled*	
☐	☐				☐ M ☐ F	☐ Child ☐ Disabled*	
☐	☐				☐ M ☐ F	☐ Child ☐ Disabled*	
☐	☐				☐ M ☐ F	☐ Child ☐ Disabled*	

**Check this box only if enrolling a disable dependent child age 26 or over and if disability occurred prior to limit age.*

Eligibility Note: Primary applicant and their dependent(s) must enroll at initial enrollment to be eligible for coverage. Dependents who waive coverage must have a qualifying event or wait until open enrollment to come on at a later date. An eligible dependent(s) declining coverage cannot enroll at a later date unless the dependent(s) can show proof of loss of prior coverage. An eligible dependent(s) is an individual's spouse/domestic partner, and any child of the enrolled applicant or coverage. An eligible dependent(s) is an individual's spouse/domestic partner, and any child of the enrolled applicant or spouse/domestic partner, who is under age 26. Dependent children may remain on this plan to age 26. If an enrolled member would like to enroll their dependents, the dependent must have a qualifying event or wait until open enrollment.

3. INVOICE AND PAYMENT PREFERENCES	
Invoices	☐ Mailed and/or ☐ Emailed (Email to: _____) or ☐ Same email as above
Initial Payment Mode	☐ Check ☐ ACH Draft (complete section 4)
Ongoing Payment Mode	☐ Check paid monthly - Due by the 1st business day of each month ☐ ACH Draft paid monthly - Drafted on the 1st business day (complete section 4)
Initial Payment: Initial payment is required. Please make check payable to Pathian Administrators. Future payments can be mailed to Pathian Administrators, P.O. Box 17791, Denver, CO 80217-0768. **Ongoing Payment:** This is a prepaid plan and monthly payments are due no later than the first day of the coverage month. Late fees will apply if not paid by the 15th of the month it's due and the group is subject to cancellation if not paid by the last day of the month it's due.	
Monthly Administration Fee	**$5.00 administration fee will apply to invoice each month.**

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4. ACH PAYMENT AUTHORIZATION - PLEASE ATTACH A COPY OF A VOIDED CHECK

Account Holder's Name:	
Name of Bank:	
Bank Address:	
Bank Routing Number: ⑆ [ ][ ][ ][ ][ ][ ][ ][ ][ ] ⑆	**Bank Routing #:** *The routing code is the 9-digit number on the lower left of your check. The routing code appears between the ⑆ symbols.*
Account Number: ⑆ [ ][ ][ ][ ][ ][ ][ ][ ][ ] ⑈	**Account #:** *Your account number can be found between the second ⑆ symbol and the ⑈ symbol. Do not include the check number (the digits to the right of the ⑈ symbol.*

I am authorizing **Pathian Administrators** to initiate debits from my checking account named above. This authority will remain in effect until I notify them 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 Pathian at (800) 786-6525. Please attach a copy of a voided check.

Signature of Account Holder: (X)	
Print Name:	**Date:**

5. VISION COVERAGE SELECTION

Voluntary Vision Service Plan
Rates effective January 1, 2020 through December 31, 2020. This plan renews every January.

Choose Plan Option(s)	Plan #	Plan Name	Employee Only	Employee +1 or Employee + Children	Employee + Family
☐	0009	Choice A - $15/$30 | 12/24/24	$8.55	$13.34	$20.87
☐	0010	Choice B - $15/430 | 12/12/24	$11.36	$17.91	$28.28
☐	0025	Signature C - $15/$30 | 12/12/12	$17.32	$27.24	$42.94

These VSP plans are only available to individuals and families residing in one of the following states: CA, CO, GA, IA, IL, IN, KS, MI, MN, MO, NC, NH, NV, OH, OK, SC, TN, TX, and WV.

All Vision Eligibility: Eligible employees must enroll at initial enrollment, or within 30 days of a qualifying event. Eligible employees declining dependent coverage cannot enroll their dependents at a later time unless the dependents show proof of loss of prior coverage. An eligible dependent is an employee's spouse/domestic partner and any child of the enrolled applicant or spouse/domestic partner who is under age 26. It is the employee's responsibility to inform the group administrator of any change in status of his/her dependents. Dependent children may remain on this plan to age 26.

6. DENTAL COVERAGE SELECTION

Voluntary Ameritas PPO Dental
Rates effective January 1, 2020 through December 31, 2020. This plan renews every January.

Choose ONE Plan	Plan #	Plan Name	Employee Only	Employee +1 or Employee + Children	Employee + Family
☐	Plan #1	$1,000	$33.73	$60.71	$93.54
☐	Plan #2	$1,250	$48.29	$89.40	$147.81

These Ameritas PPO Dental plans are only available to individuals and families residing in AZ, CA, NV, and UT.

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7. SIGNATURE

I certify on behalf of my eligible family dependents and myself that the answers contained in this application are complete and accurate to the best of my knowledge. I am at least 18 years of age. It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance carrier for the purpose of defrauding or attempting to defraud the carrier. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Division of Insurance within the Department of Regulatory Agencies.

We understand that any dispute between us and Ameritas, VSP, Warner Pacific, and/or Pathian must be resolved through binding arbitration if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court and not by lawsuit or court process, except as California providers for judicial review of arbitration proceedings.

I also understand that the current rates are guaranteed from January 2020 through December 2020. These plans renew every January regardless of the original effective date. A $5.00 administration fee will apply to invoice each month.

Signature of Primary Member: (X)	**Date:**
Print Name:	

8. AGENT INFORMATION		
Agent Name:		Inshore Agent ID #:
License #:	State Issued:	Expiration (MM/YY):
Mailing Address:		
City:	State:	Zip Code:
Agency Name:		
Agency Mailing Address (if different):		
City:	State:	Zip Code:
Email:	Phone:	Fax:
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 Pathian that the coverage being requested by this application is accepted. Upon first submission, the agent or agency must provide copy of current Producer License and a completed W-9.		

Agent Signature: (X)	**Date:**
Agent Name (Print):	