



Employer Application
All states (excluding VT, WA)

FOR OFFICE USE ONLY
Billing #:

SIGN UP TO START SAVING!
1. Complete Plan and Payment Details box.
2. Enter Employer Information.
3. Enter Invoice and Payment Preferences.
4. Company Officer signs application.
5. Enter EFT payment information.
6. Return Employer Application and Employee Application(s) to agent to sign and return to: CAnewbusiness@warnerpacific.com for processing.
Questions about enrollment? Please call Inshore Benefits at (800) 801-2300.

1. PLAN AND PAYMENT DETAILS
Requested Effective Date:
Plan Name: AlphaUS POS Dental Plan
Table with 2 columns: Plan Details, Amount
1 person: \$8.75 x \_\_\_\_ (# ee's)
2 persons: \$15.00 x \_\_\_\_ (# ee's)
3+ persons: \$16.50 x \_\_\_\_ (# ee's)
Monthly Admin Fee: \$15.00
Total: \$\_\_\_\_\_
Discount Vision & Prescription Drug Services Free!!!

2. EMPLOYER INFORMATION

Preferred Company Name or DBA:
Company Tax ID: Phone:
Physical Address:
City: State: Zip Code:
Mailing Address (if different):
City: State: Zip Code:
Group Administrator: Email:

3. INVOICE & PAYMENT PREFERENCES

Invoice Delivery via: [ ] Mail [ ] Email to \_\_\_\_\_ or [ ] Same email as Group Administrator in Section 1
Payment Mode: [ ] ACH Draft (Complete Section 5)
Monthly Administration Fee: \$15.00 administration fee will apply to invoice each month \_\_\_\_\_ Initial for acknowledgment of fees and terms

4. EMPLOYER SIGNATURE

Participation Agreement: We, the undersigned group, understand that we are applying for membership in the North Ranch Benefit Trust (Inshore Benefits). AlphaUS, Ameritas, Delta Dental, Guardian, Humana, and Vision Service Plan (VSP) has issued a master policy to Inshore Benefits 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, AlphaUS, Ameritas, Delta Dental, Guardian, Humana, VSP and/or Pathian reserve the right to reject this application.
We, the undersigned group, understand that we have an obligation to ensure that all persons offered benefits meet eligibility requirements and that coverage is offered to every eligible person. We understand that we will be liable for any claims incurred during any period in which we do not meet the participation and eligibility maintenance requirements. We understand that AlphaUS, Ameritas, Delta Dental, Guardian, Humana, VSP and/or Pathian will rely on the representations contained in this document and any others, such as applications, which we provide in determining whether they will accept us as an eligible group.
It is understood that coverage for any benefits shall not commence until a completed Employer Application has been approved by AlphaUS, Ameritas, Delta Dental, Guardian, Humana, VSP and/or Pathian, its authorized agents, or representatives; the first month's premium for the purchased benefit plan(s) has been paid; all completed employee applications have been submitted; and notice of said approval has been transmitted in writing. We certify that the answers on any and all applications are true and understand that coverage may be rescinded should it be determined at a future date that there are misstatements in the applications.
Some of the contracts AlphaUS, Ameritas, Delta Dental, Guardian, Humana, VSP hold with Warner Pacific Insurance Services (Warner Pacific) provide for payment of incentives, compensation, excess surplus and bonuses (compensation). In the sole and exclusive discretion of Warner Pacific, such compensation may be retained by Warner Pacific or distributed to other parties. Such compensation will not be returned to you as the employer/plan sponsor. Any benefits claims submitted under your policy/certificate will be paid without regard to such compensation.
Arbitration Agreement: We understand that any dispute between us and AlphaUS, Ameritas, Delta Dental, Guardian, Humana, VSP 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 provides for judicial review of arbitration proceedings.
I certify that all of the information provided in this document is accurate to the best of my knowledge as of the date signed. A \$15.00 administration fee will apply to invoice each month.

Signature of Company Officer: Title:
Name (print): Date:

**EMPLOYER INFORMATION**

Employer Name:

**5. PAYMENT INFORMATION**

Name of Bank:

Branch:

Bank Address:

City: <input style="width: 400px; height: 19px;" type="text"/>	State: <input style="width: 100px; height: 19px;" type="text"/>	Zip Code: <input style="width: 150px; height: 19px;" type="text"/>
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Bank Routing Number: I: <input style="width: 200px; height: 19px;" type="text"/> I:	The <b>Bank Routing Number</b> is the 9-digit number on the lower left of your check. This routing code appears between the I: symbols.
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Account Number: I: <input style="width: 200px; height: 19px;" type="text"/> II <sup>®</sup>	The <b>Account Number</b> is the number that can be found between the second I: symbol and the II <sup>®</sup> symbol. Do not include the check number (the digits to the right of the II <sup>®</sup> symbol.)
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Please check one:  **Checking Account**     **Savings Account**

**I authorize Pathian Administrators to initiate electronic entries to my checking/savings account and have agreed to the terms listed on the authorization. I may revoke my authorization with the company at any time by writing to Pathian Administrators at the address above. If the payment amount changes, we will notify you at least 10 days before the regularly scheduled payment date. Please give a 7-day notice to Pathian if you wish to stop a future draft by emailing: inshore@pathianadministrators.com**

Signature of Account Holder:

Print Name: <input style="width: 600px; height: 19px;" type="text"/>	Date: <input style="width: 100px; height: 19px;" type="text"/>
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**6. AGENT INFORMATION**

Agent Name: <input style="width: 600px; height: 19px;" type="text"/>	Inshore Agent ID #: <input style="width: 100px; height: 19px;" type="text"/>
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License #: <input style="width: 300px; height: 19px;" type="text"/>	State Issued: <input style="width: 100px; height: 19px;" type="text"/>	Expiration (MM/YY): <input style="width: 150px; height: 19px;" type="text"/>
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Mailing Address:

City: <input style="width: 400px; height: 19px;" type="text"/>	State: <input style="width: 100px; height: 19px;" type="text"/>	Zip Code: <input style="width: 150px; height: 19px;" type="text"/>
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Agency Name:

Agency Mailing Address (if different):

City: <input style="width: 400px; height: 19px;" type="text"/>	State: <input style="width: 100px; height: 19px;" type="text"/>	Zip Code: <input style="width: 150px; height: 19px;" type="text"/>
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Email: <input style="width: 300px; height: 19px;" type="text"/>	Phone: <input style="width: 100px; height: 19px;" type="text"/>	Fax: <input style="width: 150px; height: 19px;" type="text"/>
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**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: <input style="width: 600px; height: 19px;" type="text"/>	Date: <input style="width: 100px; height: 19px;" type="text"/>
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Agent Name (Print):