FOR OFFICE USE ONLY Billing #:	

For plans effective on/after 1/1/2024. Rates are subject to change.
Check inshorebenefits.com for most current rates.

Employer Application
All States (excluding VT, WA)

Sign Up to Start Saving!

1. Complete Plan and Payment Details box
2. Enter Employer Information
3. Enter Invoice & Payment Preferences
   a. Plan requires automatic recurring payment(EFT)on the 3rd of each month.
   b. Invoices will be emailed each month to email address listed below, about three weeks before due date and EFT draft.
   c. Invoices and payments are processed by Pathian Administrators. Pathian can be reached at 1-800-786-6525.
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 1-800-801-2300.

1. PLAN AND PAYMENT DETAILS

Requested Effective Date:	
Plan Name: AlphaUS POS Dental Plan	
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: ☐ 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 Inshore Benefits Trust ("Trust"). AlphaUS, Ameritas, Delta Dental, Guardian, Humana, 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, 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 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 employeeapplications 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 andunderstand 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, and 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 Pacificor 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 willbe paid without regard to such compensation.

Arbitration Agreement: We understand that any dispute between us and AlphaUS, Ameritas, Delta Dental, Guardian, Humana, VSP, Warner Pacific and/or Pathian must be resolvedthrough 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 Californiaprovides 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:**

Alpha Dental Plan

inshore

EMPLOYER INFORMATION

Employer Name:

5. PAYMENT INFORMATION

Name of Bank:		
Branch:		
Bank Address:		
City:	State:	Zip Code:
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.*	
This is a Checking or 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 if you wish stop a future draft, email inshore@pathianadministrators.com.

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

6. 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):	