Inshore Benefits
Employee Application — CA

Employer Name:	Billing #:

1. EMPLOYEE INFORMATION		Requested Effective Date:
Employee First Name:	Employee Last Name:	
Social Security #:	Date of Hire:	
Mailing Address:		
City:	State:	Zip Code:
Primary Phone:	Email:	

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

2. QUALIFYING EVENT & DATE ☐ **New Coverage** (give reason below) **Date of Qualifying Event:**

☐ New Group Enrollment ☐ Open Enrollment ☐ New Hire ☐ Rehire within 30 days - Reinstate to term date

☐ Rehire more than 30 days - subject to group's new hire waiting period ☐ Part-time to Full-time ☐ Waiving Coverage ☐ Other _____

New Group Enrollment: Eligible employees and their dependents must enroll at initial new group enrollment to be eligible for coverage. Members who waive coverage must have a qualifying event or wait until open enrollment to enroll on the plan at a later date.

New Hire or Member with Qualifying Event: We must receive the completed application within 30 days of the date of hire or of the qualifying event.

Late Enrollee: A late enrollee is an employee and/or their dependent(s) who has submitted their Enrollment Application more than 30 days after their eligibility date. These employee's and/or dependent(s) must have a qualifying event to enroll at a later date and provide proof of the qualifying event. Otherwise, the employee will not be eligible for coverage until the group's open enrollment period.

Dependent(s): 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. An eligible dependent(s) declining coverage cannot enroll at a later date unless the dependent(s) can show proof of loss of prior coverage. The dependent(s) must have a qualifying event or wait until open enrollment.

3. PLAN SELECTION (Options available are based upon your employer's offering).

Ameritas Dental	Ameritas Vision	Delta Dental of CA	Guardian Dental	Humana Dental	Vision Service Plan
☐ Dental	☐ Vision	☐ PPO ☐ DHMO	**Employer Sponsored:** ☐ 1500 Standard PPO ☐ 1500 UCR PPO ☐ 2000 Standard PPO ☐ 2500 UCR PPO ☐ DHMO **Voluntary:** ☐ 1500 Standard PPO ☐ Split Value PPO ☐ DHMO	☐ PPO 14 Unlimited ☐ PPO 14 Traditional Preferred 1500 ☐ PPO 14 Preventive Plus 1000 ☐ DHMO LS200	☐ PPO
Locate provider at: www.ameritas.com	Locate provider at: www.ameritas.com	DHMO Primary Dentist: _____ Locate provider at: www.deltadentalins.com	DHMO Primary Dentist: _____ Locate provider at: www.guardiananytime.com	DHMO Primary Dentist: _____ Locate provider at: www.humana.com	List name of plan selection: _____ Locate provider at: www.vsp.com
☐ Employee ONLY ☐ Employee +1 ☐ Employee +2 or more	☐ Employee ONLY ☐ Employee +1 ☐ Employee +2 or more	☐ Employee ONLY ☐ Employee +1 ☐ Employee +2 or more	☐ Employee ONLY ☐ Employee +1 ☐ Employee +2 or more	☐ Employee ONLY ☐ Employee +1 (spouse or 1 child) ☐ Employee + Children ☐ Family	☐ Employee ONLY ☐ Employee +1 (spouse or 1 child) ☐ Employee + Children ☐ Family

4. DENTAL WAITING PERIODS

Voluntary Delta Dental of CA and Voluntary Humana Dental plans have a 12 month major service waiting period for services. This may be waived if proof of 12 months of continuous prior coverage is included with this application. Please provide a copy of your dental ID card with this application.

Who is your current dental carrier? ☐ Proof of prior coverage attached **Dates of coverage from:** **to:**

5. EMPLOYEE ENROLLMENT INFORMATION

Dental	Vision	First Name	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*	

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

I certify on behalf of my eligible 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.

Employee Signature: (X)	**Date:**

Inshore Benefits is a product portfolio of North Ranch Benefits Trust | Website: InshoreBenefits.com
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