



Inshore Benefits

Employer Application

For plans effective 7/1/2024. Rates are subject to change.
Check [inshorebenefits.com](https://www.inshorebenefits.com) for most current rates.

VSP Vision: Available in all states, excluding CA and CO
Guardian PPO Dental: Available in all states, excluding CA
Guardian HMO Dental: Available in: CO, FL, IL, IN, MI, MO, NY, NJ, OH and TX

Requested Effective Date:

FOR OFFICE USE ONLY
Billing #:

1. EMPLOYER INFORMATION

Preferred Company Name or DBA:		Phone:
Company Tax ID:	SIC Code*:	*(Required for dental coverage)
Physical Address:		
City:	State:	Zip Code:
Mailing Address (if different):		
City:	State:	Zip Code:
Group Administrator:	Email:	

*SIC code is required. Certain industries are ineligible to purchase Inshore Dental plans with Ameritas, Delta Dental, and Humana, such as: Dental Offices 8021, Dental Labs 8071, Medical Labs 8072, and Seasonal Employees, Part-time help and groups without an SIC.

2. GROUP ELIGIBILITY INFORMATION

Total # of Employees :	Total # of Eligible Employees :	Total # of Enrolling Employees :
New hire waiting period is first of the month following: Date of Hire 1 Month 2 Months 3 Months		
Is your group currently subject to: Federal COBRA (Employed 20+ eligible employees on at least 50% of its working days in the previous calendar year*) State COBRA (If so, please indicate state: _____ *)		
*Check with your State Department of Labor for local eligibility rules or visit www.DOL.gov for more COBRA eligibility information.		

3. INVOICE & PAYMENT PREFERENCES

Invoice Delivery via:	Mail	Email to _____	or	Same email as Group Administrator in Section 1
Payment Mode:	Check	ACH Draft (ACH Authorization Form attached)		
Payment Terms: Initial payment is required with application. Please make check payable to Pathian Administrators and mail to Pathian, 32110 Agoura Road, Westlake Village, CA 91361. 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 month due. If not paid by the last day of the month, group is subject to cancellation and subsequent reinstatement fee of \$25.00.				
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:

Inshore Benefits is a product portfolio of North Ranch Benefits Trust | Website: [InshoreBenefits.com](https://www.InshoreBenefits.com)
Inshore Benefits is marketed by Warner Pacific Insurance Services, Inc. | Phone: (800) 801-2300 | Fax: (800) 609-0111 | Email: quoting@warnerpacific.com
Inshore Benefits is administrated by Pathian Administrators | Phone: (800) 786-6525 | Fax: (818) 960-0141 | Email: inshore@pathianadministrators.com



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5. EMPLOYER SPONSORED OPTIONS

- Monthly Administration Fee: \$15 / month / invoice
- Plan Type: Employer Sponsored
- Contributions: Employer can contribute 50% - 100% of premiums

Vision Service Plan (VSP)

Available to groups headquartered in: Any state, except CA and CO
Employees can reside in: Any state for PPO plans
Participation: Minimum of 3 enrolled employees
Plan Selection(s): Employer can choose one PPO option

Choose One	Plan Number	Plan Type	Plan Name	Employee Only	Employee + Spouse	Employee +1 Child	Employee +Children	Employee +Family
	0096	Vision	Choice \$150 A \$10/\$25	\$6.85	\$11.17	\$11.17	\$11.78	\$17.66
	0097	Vision	Choice \$160 B \$10/\$25	\$8.59	\$14.63	\$14.63	\$15.48	\$23.23
	0098	Vision	Choice \$180 B \$0	\$9.71	\$16.88	\$16.88	\$17.88	\$27.06
	0099	Vision	Choice \$180 C \$10/\$10	\$10.08	\$17.64	\$17.64	\$18.71	\$28.37
	0100	Vision	Choice \$200 EasyOptions	\$11.09	\$19.66	\$19.66	\$20.86	\$31.83
Choose One	VSP Participation Options: The employer must choose one of the following participation options. (Required)							
	Option 1: VSP participation and contribution matches employer-sponsored medical plan participation exactly.							
	Option 2: VSP participation and contribution matches employer-sponsored dental plan participation exactly.							
	Option 3: VSP participation is 100% employer paid, and all eligible employees and all eligible dependents are enrolled.							
	Option 4: VSP participation is 100% employer paid and all eligible employees and no dependents are enrolled.							

6. VOLUNTARY OPTIONS

- Monthly Administration Fee: \$15 / month / invoice
- Plan Type: Voluntary
- Contributions: Employer can contribute 0% - 100% of premiums

Guardian Dental (Voluntary)

Available to groups headquartered in: Any state, except CA
Employees can reside in: Any state for PPO plans
Employees can reside in: CO, FL, IL, IN, MI, MO, NY, NJ, OH, or TX for HMO plans
Participation: Minimum of 2 enrolled in each plan
Plan Selection(s): Employer can choose one or more plan options

Choose Plan(s)	Plan Number	Plan Type	Plan Name	Employee Only	Employee + Spouse	Employee +1 Child	Employee +Children	Employee +Family
	DT F0059A	PPO	2500 UCR	\$69.67	\$134.66	\$134.66	\$248.07	\$248.07
	DT F0060I	PPO	1500 MAC	\$60.16	\$116.07	\$116.07	\$152.52	\$152.52
	4H G0073G	HMO	HMO (Available in CO, FL, IL, IN, MI, MO, NY, NJ, OH, TX)	\$17.87	\$31.96	\$31.96	\$51.88	\$51.88

Vision Service Plan (VSP) (Voluntary)

Available to groups headquartered in: Any state, except CA and CO
Employees can reside in: Any state for PPO plans
Participation: Minimum of 1 enrolled
Plan Selection(s): Employer can choose one or more voluntary PPO options

Choose Plan(s)	Plan Number	Plan Type	Plan Name	Employee Only	Employee + Spouse	Employee +1 Child	Employee +Children	Employee +Family
	0031	Vision	Choice \$150 A \$10/\$25	\$7.60	\$12.66	\$12.66	\$13.38	\$19.87
	0032	Vision	Choice \$160 B \$10/\$25	\$9.18	\$15.84	\$15.84	\$16.77	\$25.28
	0033	Vision	Choice \$180 B \$0	\$10.58	\$18.63	\$18.63	\$19.76	\$30.05
	0034	Vision	Choice \$180 C \$10/\$10	\$11.02	\$19.53	\$19.53	\$20.72	\$31.60
	0035	Vision	Choice \$200 EasyOptions	\$13.22	\$23.91	\$23.91	\$25.40	\$39.09

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

Name of Account Holder:		
Bank Name:		
Bank Address:		
City:	State:	Zip Code:
Bank Routing Number: I: <input type="text"/> I:	The Bank Routing Number is the 9-digit number on the lower left of your check. This routing code appears between the I: symbols.	
Account Number: I: <input type="text"/> II:	The Account Number is the number that can be found between the second I: symbol and the II: symbol. Do not include the check number (the digits to the right of the II: symbol.)	
Please check one: <input type="checkbox"/> Checking Account <input type="checkbox"/> 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:		Date:

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:		Date: