Inshore Benefits
Individual/Family Application

For rates effective 1/1/2024 - 12/31/2024.
Rates are subject to change.
Check www.inshorebenefits.com for most current rates.

1. MEMBER INFORMATION		Requested Effective Date:
First Name:	Last Name:	
Social Security #:	What is your communication preference? ☐ Mail ☐ Email	
Home 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 ☐ Emailed (Email to: _____) or ☐ Same email as above		
Payment Options: Initial payment is required with application, via Check or ACH Draft.			
☐ **CHECK**	**Please make check payable to :** Pathian Administrators. **Future payments can be mailed to:** Pathian Administrators, P.O. Box 17791, Denver, CO 80217-0768	☐ **AUTOPAY VIA ACH DRAFT**	Drafted on the third business day of each month. ***Please complete section 4.***

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 of which payment is due and is subject to cancellation if not paid by the last day of the month of which it is due.

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) 801-2300. Please attach a copy of a voided check.

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

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Guardian

Dental INDIVIDUAL Benefit and Rate Sheet

HMO Available in CO, FL, IL, IN, MI, MO, NY, NJ, OH, TX[1]
PPO Available in all states, except CA[2]

CHOOSE ONE:					
Plan Name	☐ **HMO 4H G0073G**	☐ **PPO 1500 MAC W/ORTHO DT F00601**		☐ **PPO 2500 UCR W/ORTHO DT F0059A**	
Network	HMO	PPO DentalGuard Preferred IN NETWORK	OUT OF NETWORK	PPO DentalGuard Preferred IN NETWORK	OUT OF NETWORK
Deductible					
Individual	N/A	$50	$50	$50	$50
Family	N/A	3 per family	3 per family	3 per family	3 per family
Waived for Preventive	N/A	Yes	Yes	Yes	Yes
Annual Max Benefit	N/A	$1500	$1500	$2500	$2500
Orthodontic Lifetime Max	1 treatment per member	$1000	$1000	$2000	$2000
Dental Benefit					
Preventive Services	$5 copay	100%	100%	100%	100%
Cleaning Allowances	1st and 2nd = $0 copay	Once every 6 months	Once every 6 months	Once every 6 months	Once every 6 months
Basic Services	See copay schedule	80%	80%	80%	80%
Endodontic	$12 - $380	Major Services 50%	Major Services 50%	Major Services 50%	Major Services 50%
Periodontal	$25 - $380	Basic Services 80% Major Services 50%	Basic Services 80% Major Services 50%	Basic Services 80% Major Services 50%	Basic Services 80% Major Services 50%
Oral Surgery	$12 - $255	Major Services 50%	Major Services 50%	Major Services 50%	Major Services 50%
Major Services	See copay schedule	50%	50%	50%	50%
Prosthodontics	$23 - $575	50%	50%	50%	50%
Implants	Yes[3]	Yes[3]	Yes[3]	Yes[3]	Yes[3]
Missing Tooth Clause	No[4]	Yes[5]	Yes[5]	Yes[5]	Yes[5]
Major Service Waiting Period	N/A	N/A	N/A	N/A	N/A
Reimbursement Schedule	HMO Copay Schedule	In/Out = Negotiated Fee	In/Out = Negotiated Fee	In = Contracted Fee Out = 80th UCR	In = Contracted Fee Out = 80th UCR
Orthodontic Benefit					
Orthodontics	You pay a copay for each covered benefit: Child to age 19: $1895 Adult: $2195	50%		50%	
Orthodontics Available To	Adult or Child	Adult or Child		Adult or Child	
Orthodontic Waiting Period	N/A	N/A		N/A	
Rates for 2024 Effective Dates - $5 administration fee applies to each monthly invoice.					
Member Only	$17.87	$60.16		$69.67	
Member + Spouse/DP	$31.96	$116.07		$134.66	
Member + 1 Child	$31.96	$116.07		$134.66	
Member + Children	$51.88	$152.52		$248.07	
Member + Family	$51.88	$152.52		$248.07	
Rate Guarantee	1 year	1 year		1 year	

1 Member must reside in CO, FL, IL, IN, MI, MO, NY, NJ, OH, or TX. Dependents must also reside in CO, FL, IL, IN, MI, MO, NY, NJ, OH, TX.
2 Member may reside in any state except CA. Dependents can reside in any state.
3 Some limitations. See Evidence of Coverage.
4 Some limitations. See Evidence of Coverage.
5 Not covered.

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Vision PPO INDIVIDUAL Benefit and Rate Sheet

vsp vision care

Available in CA & CO

CHOOSE ONE:					
Plan Name	☐ PLAN A 0009	☐ PLAN B 0026	☐ PLAN C 0027	☐ PLAN C 0030	☐ PLAN C 0029
Network	PPO CHOICE IN-NETWORK	PPO CHOICE IN-NETWORK	PPO CHOICE IN-NETWORK	PPO CHOICE IN-NETWORK EASYOPTIONS[1] LIGHTCARE[2]	PPO SIGNATURE IN-NETWORK
Benefit Frequency					
Exam/Lens/Frame	Every 12/24/24 months	Every 12/12/24 months	Every 12/12/12 months	Every 12/12/12 months	Every 12/12/12 months
Deductible/Copay					
Exam	$15	$10	$10	$10	$25
Lens/Frame	$30	$20	$20	$25	
Benefits (After Deductible/Copay)					
Exam	100%	100%	100%	100%	100%
Lenses - Single	100%	100%	100%	100%	100%
Lenses - Bifocal	100%	100%	100%	100%	100%
Lenses - Trifocal	100%	100%	100%	100%	100%
Lenses - Lens Enhancements	Subject to copays	Subject to copay	Subject to copay	Subject to copay	Subject to copay
Frame	$150[3]	$150[3]	$180[3]	$180[3]	$200[3]
Contacts - Elective (in lieu of glasses)	$180 allowance	$180 allowance	$180 allowance	$160 allowance	$180 allowance
Fit & Follow-up Exam	Up to $60 copay	Up to $60 copay	Up to $60 copay	Up to $60 copay	Up to $60 copay
Medically Necessary	100%	100%	100%	100%	100%
Rates for 2024 Effective Dates - $5 administration fee applies to each monthly invoice.					
Member Only	$8.55	$11.12	$13.28	$13.60	$15.57
Member + Spouse/DP	$13.34	$19.42	$23.75	$24.69	$28.33
Member + 1 Child	$13.34	$19.42	$23.75	$24.69	$28.33
Member + Children	$13.34	$19.42	$23.75	$24.69	$28.33
Member + Family	$20.87	$29.54	$36.50	$38.22	$43.87
Rate Guarantee	2 years	2 years	2 years	2 years	2 years

1 EasyOptions - Choose your upgrade - $260 Frame Allowance, or Anti-glare Lenses, or Progressive Lenses, or Light-reactive Lenses, or in lieu of glasses a $260 Contact Lens allowance. VSP EasyOptions plan benefits are not available at retail chains such as Walmart®, Sam's Club®, or Costco.

2 LightCare - You can use your frame and lens benefit to get non-prescription (ready-to-wear) eyewear from your VSP network doctor. Such as non-prescription sunglasses or blue light filtering glasses.

3 Coverage with a retail chain, Walmart®, Sam's Club®, or Costco may be different or not apply; such as $90 Frame Allowance at retail chain. Before seeking services, contact VSP to find a VSP provider or a retail chain to discuss their allowances.

5. 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 Guardian, 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 a $5.00 administration fee will apply to my montly invoice.

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

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):	