Inshore Benefits
Employer Application — Colorado

For 2025 effective dates. Benefit and rates are subject to change, check inshorebenefits.com for the most current information.

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 which includes Ameritas, Delta Dental, Guardian 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, Inshore Benefits and Pathian reserve the right to reject this application.

We, the undersigned group, understand that we have an obligation to ensure that all person offered benefits meet eligibility requirements and that coverage is offered to every eligible person. We 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 Inshore Benefits 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 he completed employer application has been approved by Inshore Benefits and/or Pathian, it's 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 that Inshore Benefits 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 Inshore Benefits and/or Pathian must be resolved through binding arbitration if the amount in dispute exceeds the jurisdiction 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. I also understand that a $15 administration fee will apply to my invoice each month.

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

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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 one of the following states: CA or CO
Employees can reside in: Any state
Participation: Minimum of 3 enrolled employees. See options below.
Plan Selection(s): Employer can choose one PPO option

Choose One	Plan Number	Plan Type	Plan Name	Employee Only	EE+1 Dependent or EE+Children	EE+ Family
☐	0080	Vision PPO	Choice A | $0 | 12/24/24	$7.93	$13.03	$20.97
☐	0081	Vision PPO	Choice B | $0 | 12/12/24	$11.12	$16.92	$27.28
☐	0093	Vision PPO	Choice B | $10/25 | 12/12/24	$9.30	$15.89	$23.94
☐	0094	Vision PPO	Choice C | $10/25 | 12/12/12	$11.29	$19.89	$30.37
☐	0001	Vision PPO	Signature B | $10 | 12/12/24	$13.75	$20.68	$33.32
☐	0090	Vision PPO	Signature B | $10/$25 | 12/12/24	$10.63	$18.56	$28.25
☐	0068	Vision PPO	Signature C | $10 | 12/12/12	$16.79	$25.24	$40.65
☐	0091	Vision PPO	Signature C | $10/$25 | 12/12/12	$13.03	$23.36	$35.96
☐	0069	Vision PPO	Signature C | $25 | 12/12/12	$13.27	$20.18	$32.50
☐	0095	Vision PPO	Choice C $10/$25 EasyOptions+LightCare	$11.42	$20.34	$31.20

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

Delta Dental of Colorado (Voluntary)

Available to groups headquartered in one of the following states: CO
Employees can reside in: Any state
Participation: Minimum of 2 enrolled in each plan.
Plan Selection(s): Employer can choose one PPO option.

Choose One	Plan Number	Plan Type	Plan Name	Employee Only	EE+1 Dependent	EE+ Family
☐	W2881-00001	Dental PPO	PPO $750	$25.38	$45.88	$76.64
☐	W2882-00001	Dental PPO	PPO + Premier $1,500	$36.72	$67.43	$113.51
☐	W2883-00001	Dental PPO	MAC PPO $2,000	$34.83	$63.85	$107.38
☐	W2884-00001	Dental PPO	MAC PPO $1,000 +Ortho	$29.29	$54.79	$100.72

Guardian Dental (Voluntary)

Available to groups headquartered in one of the following states:
HMO Available in CO, FL, IL, IN, MI, MO, NY, NJ, OH, TX. HMO Employees must reside in the one of these states.
PPO Available in all states, except CA. PPO employees can reside in any state.
Participation: Minimum of 1 enrolled employee.
Plan Selection: Employer can choose the HMO and/or 1 PPO plan.

Choose One	Plan Number	Plan Type	Plan Name	Employee Only	EE+SP or Child	EE+2 or More
☐	4H G0073G	Dental HMO	VOL HMO	$17.87	$31.96	$51.88
☐	DT F0060L	Dental PPO	PPO 1500 MAC	$60.16	$116.07	$152.52
☐	DT F0059A	Dental PPO	PPO 2500 UCR	$69.67	$134.66	$248.07

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Vision Service Plan (VSP) (Voluntary)

Available to groups headquartered in one of the following states: CA or CO
Employees can reside in: Any state
Participation: Minimum of 1 enrolled
Plan Selection(s): Employer can choose one or more voluntary PPO options

Choose One	Plan Number	Plan Type	Plan Name	Employee Only	EE+1 OR Employee+ Children	EE+ Family
☐	0009	Vision PPO	Choice A | $15/$30 | 12/24/24	$8.55	$13.34	$20.87
☐	0026	Vision PPO	Choice B | $10/$20 | 12/12/24	$11.12	$19.42	$29.54
☐	0027	Vision PPO	Choice C | $10/$20 | 12/12/12	$13.28	$23.75	$36.50
☐	0029	Vision PPO	Signature C | $25 | 12/12/12	$15.57	$28.33	$43.87
☐	0030	Vision PPO	Choice C $10/$25 EasyOptions+LightCare	$13.60	$24.69	$38.22

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: ⑆ ⑆	The **Bank Routing Number** is the 9-digit number on the lower left of your check. This routing code appears between the ⑆ symbols.	
Account Number: ⑆ ⑈	The **Account Number** is the number that can be found between the second ⑆ symbol and the ⑈ symbol. Do not include the check number (the digits to the right of the ⑈ symbol.)	
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:		**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:**