



# Application For Vision Care Benefits

Underwritten by Fidelity Security Life Insurance Company®

Kansas City, Missouri

Policy No. VC-76

## I. EMPLOYER INFORMATION

Employer Name: \_\_\_\_\_ Tax ID#: \_\_\_\_\_

DBA Name (if other than above): \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Key Contact: \_\_\_\_\_ Title: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Email: \_\_\_\_\_

Executive Contact (if other than above): \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Email: \_\_\_\_\_

Type of Business:      Proprietorship                  Corporation                  Partnership                  Other (specify): \_\_\_\_\_

If any subsidiary or affiliated companies are to be insured or any Employees are working at a location other than the address above, please explain:

\_\_\_\_\_

\_\_\_\_\_

Will this plan replace any existing coverage:      Yes                  No (if yes, indicate name and address of existing insurer)

Name: \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

(If "yes," are any employees on COBRA)?      Yes                  No                  How many? \_\_\_\_\_

Effective date of existing coverage: \_\_\_\_\_

Termination date of existing coverage (if applicable): \_\_\_\_\_

Number of full-time employees: \_\_\_\_\_ Number applying: \_\_\_\_\_

Are domestic partners covered under this plan?\*      Yes                  No      \*except as required by state law

Unless your specific state mandates otherwise, do you wish to cover dependents until age 26, regardless of financial dependency, residency, student status or marital status?      Yes                  No

## II. PLAN SELECTION

Employer Paid	Voluntary	Contributory	Exam Copay: _____
Frequency (Exam, Lenses, Frames, Contact Lenses)			Materials Copay: _____
12 months, 12 months, 12 months, 12 months			Frame Allowance: _____
12 months, 12 months, 24 months, 12 months			Contact Lens Allowance: _____
12 months, 24 months, 24 months, 24 months			Lens Option Package (if applicable): _____
___ months, ___ months, ___ months, ___ months			LASIK Rider (\$300 or \$600): _____

Tier		3 Tier		4 Tier	
2 Tier	Rate	Employee Only	Rate	Employee Only	Rate
Employee Only	_____	Employee + One	_____	Employee + Spouse	_____
Employee + Family	_____	Employee + Family	_____	Employee + Children	_____
				Employee + Family	_____

### III. PREMIUMS

Employee contribution towards premium?:                      Yes                      No

Employer's Premium Contribution for:                      Employees (%): \_\_\_\_\_                      Dependents (%): \_\_\_\_\_

Are Employee and Dependent premiums being paid through a Section 125 Plan?                      Yes                      No

Are Employee and Dependent premiums being collected by payroll deduction?                      Yes                      No

Premium received with application: \_\_\_\_\_

Note: Please attach a list of all participants to this application. Premiums shall be payable in advance.

### IV. ELIGIBILITY (Choose One)

**PROBATIONARY PERIOD FOR NEW EMPLOYEES**                      30 days                      60 days                      90 days                      120 days                      180 days

Other: \_\_\_\_\_

Probationary Period is Waived for Present Employees:                      Yes                      No

#### ELIGIBLE CLASS (Choose One)

The Employees eligible for insurance under the Policy shall be **all the full-time Employees** of the above-named Employer and each Employee's Dependents. If both husband and wife are Employees, either the husband or wife, but not both, may elect coverage for their Dependents. Eligible Dependents may be added to the Policy on any premium due date.

As used herein, full-time Employee means an Employee who is performing all the usual duties of his or her position at the Employer's usual place of business at least \_\_\_\_\_ or more hours per week. A part-time Employee is an Employee who does not meet this definition.

Dependents may not be included as Eligible Persons unless the Dependent's parent or spouse is covered under the Policy.

The Employees eligible for insurance under the Policy shall be **all the Employees** of the above named Employer, and each Employee's Dependents. If both husband and wife are Employees, either the husband or wife, but not both, may elect coverage for their Dependents. Eligible Dependents may be added to the Policy on any premium due date.

The Employees eligible for insurance under the Policy shall be \_\_\_\_\_

#### DATE ELIGIBLE

1. Each Employee included in an Eligible Class on the Policyholder's Effective Date will be eligible on that date, provided the Employee has completed any required probationary period shown below.
2. Each Employee included in an Eligible Class on the Policyholder's Effective Date, and who had partially satisfied the required probationary period prior to the Policyholder's Effective Date, will be eligible on the first day of the calendar month coinciding with or next following the date of completion of the probationary period.
3. Each Employee who enters an Eligible Class AFTER the Policyholder's Effective Date will be eligible on the first day of the calendar month coinciding with or next following:
  - a. completion of any required probationary period; or
  - b. the Employee's date of employment, if a probationary period is not required.

#### EMPLOYEE ENROLLMENT

1. Each Employee may request coverage for him or herself and eligible Dependents.
2. The Company reserves the right, based upon Our underwriting procedures, to require that the eligible Employee and/or eligible Dependent of a Policyholder submit an enrollment form and agree to pay any premium contribution, if required, before coverage will become effective for the Employee and/or Dependent.

#### DELAYED ENROLLMENT

Each Employee who waives or declines insurance when he or she becomes eligible will not be eligible again until the next open enrollment period or qualifying event, if earlier. If insurance is waived or declined for eligible Dependents then those Dependents will not become eligible again until the next open enrollment period or qualifying event, if earlier.

#### PARTICIPATION REQUIREMENT

The Policyholder is required to maintain the minimum participation requirements of the Company as follows:

- If part of the premium is derived from funds contributed by the insured Employees, at least 10 Employees must be covered on the policy's Effective Date.
- When a contribution is not required by the Employee, then 100% of the eligible Employees must be covered at all times.

## V. EFFECTIVE DATE

It is desired that the policy shall become effective at 12:01 A.M. Standard Time at the Employer's address herein, on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, provided this application shall have been accepted by the Company.

The Policy, if issued, shall be effective for a term of \_\_\_\_\_ year(s).

The total premium rate is subject to modification based upon any change in benefits, policyholder contributions, number of eligible employees, information provided by the applicant on the application, governmental action or change in law or regulation, any of which, individually or in combination, may affect the Company's risk in underwriting this coverage. The rate guarantee is also subject to change for any regulatory assessments, fees, or taxes created by federal or state governments, and the associated administrative costs.

The Employer hereby makes application to Fidelity Security Life Insurance Company® for Vision Benefits. The Employer agrees to maintain and furnish any records necessary to administer the plan, and to pay premiums in the month they are due.

The Employer certifies that all the information shown on this application and any attachments are correct and complete and understands that the Insurance Company intends to rely on this information in determining whether or not the enrolling Employees may become insured. It is further understood and agreed that **NO INSURANCE WILL BECOME EFFECTIVE UNTIL APPROVED BY THE INSURANCE COMPANY**; and that no field representative of the Insurance Company has the authority to modify any conditions of application or policies by making any promise or representation. It is understood that the insurance as to any Employee will NOT become effective on the date insurance should otherwise become effective if he is not at work on such date performing all duties of his occupation and otherwise meets the requirements of the Insurance Company.

By signing below, the Group agrees to receive all documents and correspondence electronically and that the Group can access the internet or the email address provided. The Group understands that the Group may revoke this authorization or request specific paper documents without revoking this authorization by contacting the Company [or Administrator] by mail, email, or telephone.

**Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.**

Dated at: \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Signed for the Employer: \_\_\_\_\_ Title: \_\_\_\_\_

Separate Billing Required: Yes No (if yes, please attach names of classifications, location addresses and contact)

We wish to be included in the Avësis e-billing system: Yes No

## WRITING BROKER'S CERTIFYING STATEMENT

I certify that I have accurately recorded on this application the information supplied by the proposed policyholder(s).

Firm Name: \_\_\_\_\_

Broker Name (print): \_\_\_\_\_ Broker Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Commission Check Payable to: \_\_\_\_\_ Firm Name: \_\_\_\_\_ Tax ID#: \_\_\_\_\_

Commission Check Payable to: \_\_\_\_\_ Broker Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Broker Signature: \_\_\_\_\_ Phone: \_\_\_\_\_

This application signed this: \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

## APPLICATION INSTRUCTIONS

Complete this application form. Be sure to sign where indicated above.

Checks should be payable to Fidelity Security Life Insurance Company® and sent to:

Avësis Third Party Administrators, LLC  
PO Box 842531  
Los Angeles, CA 90084-2531