



Administered by Avesis Third Party Administrators, Inc.

# Application for Vision Care Benefits

Underwritten by Fidelity Security Life Insurance Company

Kansas City, Missouri

Policy No. VC-16/VC-23

## I. EMPLOYER INFORMATION

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

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

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

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
(if other than above)

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

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Executive Contact: \_\_\_\_\_

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

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: \_\_\_\_\_

Domestic partners are covered under this plan?  Yes  No

## II. PLAN SELECTION

Employer Paid

Voluntary

- AVESIS Advantage Vision Basic Plan
- AVESIS Advantage Vision Enhanced Plan
- AVESIS Advantage Vision Plus Plan
- AVESIS Advantage Vision Preferred Plus Plan
- Other \_\_\_\_\_

	Exam	Lenses	Frame	Contact Lenses
<input type="checkbox"/>	12 months	12 months	12 months	12 months
<input type="checkbox"/>	12 months	12 months	24 months	12 months
<input type="checkbox"/>	12 months	12 months	24 months	24 months
<input type="checkbox"/>	12 months	24 months	24 months	24 months
<input type="checkbox"/>	24 months	24 months	24 months	24 months
<input type="checkbox"/>	__ months	__ months	__ months	__ months

Select Tier Structure:  2 Tier  3 Tier  4 Tier

Co-payment: \$ \_\_\_\_\_ Examination \$ \_\_\_\_\_ Other  
\$ \_\_\_\_\_ Frames/Lenses \$ \_\_\_\_\_ Other

	No. of employees	Rate		Total Remittance
Employee Only	_____	X \$ _____	=	\$ _____
Employee + Spouse	_____	X \$ _____	=	\$ _____
Employee + Child(ren)	_____	X \$ _____	=	\$ _____
Employee + Family	_____	X \$ _____	=	\$ _____
		<b>TOTAL</b>	=	\$ _____

### 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. This list may be a hard copy or diskette.)

Premiums shall be payable in advance.

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### 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 above.
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 his 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 \_\_\_\_\_, 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 \_\_\_\_\_, 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 \_\_\_\_\_, 200\_\_ , provided this application shall have been accepted by the Company.

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

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 monthly in advance.

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.

Dated at: \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_\_\_\_

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 Avesis e-billing system:  Yes  No

ID Cards to be mailed to:  Cardholder  Employer  Avesis

**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 No.: \_\_\_\_\_

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 \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_\_\_\_

**APPLICATION INSTRUCTIONS**

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

Return the completed application form along with the first month's premium payable to FIDELITY SECURITY LIFE INSURANCE COMPANY to:

Avesis Third Party Administrators, Inc.  
P.O. Box 316  
Owings Mills, Maryland 21117

Subsequent payments to be payable to FIDELITY SECURITY LIFE INSURANCE COMPANY and sent to:

Avesis Third Party Administrators, Inc.  
P.O. Box 52718  
Phoenix, Arizona 85072