

APPLICATION FOR GROUP VISION CARE PLAN



VSP
P.O. Box 997100 • Sacramento • California 95899-7100
(800) 852-7600
Attn: Inside Sales

All applicable questions must be completed accurately and in detail to avoid delay.
Please type or print all information.

GROUP INFORMATION

1. Full legal name of group as it appears on the policy: _____
Address _____
City _____ County _____ State _____ Zip _____
Telephone (_____) _____ Fax (_____) _____
Principal Contact _____ Title _____ E-mail _____
2. Who should we contact with payment questions? _____ Title _____
Telephone (_____) _____ Fax (_____) _____ E-mail: _____
3. Who should we contact with eligibility questions? _____ Title _____
Telephone (_____) _____ Fax (_____) _____ E-mail: _____
4. Is someone other than the principal contact responsible for the overall administration of the plan (benefits administrator)?
Name _____ Title _____
Telephone (_____) _____ Fax (_____) _____ E-mail: _____
If multiple benefits administrators are at other locations, please attach separate piece of paper, with name(s), address(es), email address(es), telephone and fax numbers.
5. What is your Standard Industry Code (SIC)? _____
What is the nature of your business? _____
6. Membership updates will be made via a secure Internet site. Do you have Internet access? Yes No
Employers without Internet access for making membership updates will be contacted by VSP to review other options.
- 7a. Names of separate divisions that will be covered by this plan:

- 7b. Will a separate billing be needed for the above divisions? Yes No
Billing address (if applicable):
Firm/Organization _____
Address _____
City _____ State _____ Zip _____
Telephone (_____) _____ Fax (_____) _____ E-mail: _____

GROUP INFORMATION CONTINUED

- 7c. If Self-Funded Program, do claims billings and administrative fee billings go to the same person? Yes No
(If no, please supply contact, title, address, telephone, and fax number for each type of billing.)
8. Send employee benefit information* to: Group's Benefit Administrator Third Party Administrator Broker/Consultant
*Any non-VSP-created information outlining coverage or plan details should be reviewed by VSP prior to distribution to members.
9. Number of employees eligible for benefits _____.
Does this represent the total number of employees in the company? Yes No (fill in total number) _____.
10. Dependents: Eligible dependents are the covered employee's spouse and unmarried dependent children until they reach their _____ birthday (also includes an unmarried child if incapable of self-support because of physical or mental incapacity that commenced prior to reaching the above age), or their _____ birthday, if attending school full-time.
Dependents other than employee's children: parents domestic partners (all) domestic partners (same sex only)
 domestic partner's children
11. Third party administrator (if applicable):
Firm _____
Address _____ E-mail _____
City _____ State _____ Zip _____
Contact _____ Title _____
Telephone (_____) _____ Fax (_____) _____

POLICY DETAILS

The rates listed must support the plan design and benefit level selected and must meet all eligibility requirements. Please refer to your VSP provided rate sheet for details or contact your VSP Account Executive. Any discrepancies may preclude acceptance by VSP.

12. Benefit Year: (Select One)
 Service Year (from last date of service)
 Calendar Year (available for groups with January 1 effective dates only)
13. Is Vision packaged with Medical Dental Voluntary Plan Other
14. Plan Type: VSP Signature Exam Plus Exam Plus w/Allowances
 Exam w/Voluntary Materials (available only for groups with 200+ ees)
 Voluntary Pool — 0-24% employer contribution (available only for groups with 200+ ees and a minimum of 50 enrolled ees)
 Voluntary Pool — 25% or more employer contribution (available only for groups with 200+ ees and a minimum of 50 enrolled ees)
 Core Employee/Voluntary Dependent Coverage (available only for groups with 200+ enrolled ees)
15. Frequency of Service: A (12/24/24) B (12/12/24) C (12/12/12) Other _____
Co-Payment: \$ _____ Total co-payment (applies to exam and eyewear) **OR** Split \$ _____ Exam/\$ _____ Eyewear
16. Group has purchased **Enhancements or Specialty Care**: Yes No
 Covered Contact Lenses Second Pair of Glasses Vision Therapy Primary Eyecare Safety EyeCare
 Computer VisionCare Preferred Laser VisionCare (only available to self-funded clients with 200 or more employees)
 Scratch Coating Anti-Reflective Coating Progressive Lenses Elective Contact Lens \$135 Allowance
 Frame Buy-up (\$50 WFA/\$130 RFA) Frame Buy-up (\$54 WFA/\$140 RFA) Frame Buy-up (\$58 WFA/\$150 RFA)
Additional Information _____

(Enhancements or Specialty Care benefit service frequency must match the base plan)

POLICY DETAILS CONTINUED

17. *FOR FULLY INSURED PROGRAMS:*

(VSP will bill you for your first month's premium)

First month's premium remittance calculation:

	EMPLOYEES		RATE		TOTAL REMITTANCE
Employee only or composite	_____ x		\$ _____	=	\$ _____
Two, Three or Four-rate basis	_____ x		\$ _____	=	\$ _____
	_____ x		\$ _____	=	\$ _____
	_____ x		\$ _____	=	\$ _____
			TOTAL =		\$ _____

Note: A minimum of 50 enrolled employees is required for a Voluntary Pooled plan. Membership is due with the receipt of the application to ensure qualification for coverage and acceptance by VSP.

18. *FOR SELF-INSURED PROGRAMS:*

Administrative Fee: Fixed fee _____ **or** Percent of claims _____

Amount of Advance Payment required for an Administrative Services Program.

\$ _____ (per covered employee - as quoted) x _____ = \$ _____
(number of employees)

19. Requested effective date *(The effective date should not precede date of receipt of this application by VSP.)*

This policy will become effective on the first day of _____, _____, provided that all of the following has been completed prior to this effective date:
(Year)

- A. Application has been received and accepted by VSP.
- B. VSP has been furnished the required information of all employees that will be covered under this policy showing name, Social Security number, and number of dependents, if applicable.
- C. Membership has been received and accepted by VSP, if applicable.

20. This agreement will continue in force 24 months from the effective date. Rates are based on the assumption that VSP will receive these amounts over the full plan term. Financial penalties may apply in the event of early termination of the contract.

21. 5500 Report Information:* Fiscal Year _____ through _____

5500 Report will be sent to the person named as the principal contact. A copy of the report may also be sent to your broker and/or your third party administrator.

Please send an additional copy to: _____

* Available for clients with 200 or more employees

22. Prior VSP coverage: Yes No

If yes, prior group name _____

23. Names of affiliates or subsidiaries with VSP coverage under a separate contract:

AGREEMENT

The undersigned group hereby applies for vision care coverage through VSP.

It is understood that:

- A. All future employees will be covered when they become eligible.
- B. Coverage will terminate for an employee on the last day of the month in which employment terminates.
- C. Member past service for groups previously covered by VSP will carry over and remain in force.
- D. This agreement will continue in force 24 months from the effective date. Rates are based on the assumption that VSP will receive these amounts over the full plan term. Financial penalties may apply in the event of early termination of the contract.

This application signed this _____ day of _____, _____ (Year)

Firm/Organization _____

Name _____ Title _____

Signature _____

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

BROKER/CONSULTANT

The broker/consultant indicated below is hereby designated Broker of Record by the above signed employer.

(Please Print)

Firm Name _____

Address _____

City _____ County _____ State _____ Zip _____

Telephone (_____) _____ Fax (_____) _____

Contact _____ Title _____ E-mail _____

Broker's Assistant Name _____ E-mail _____

Taxpayer I.D. # _____

Type of firm: Corporation Independent

Commission Checks Payable to: Firm Name Contact Name Not Paid

Commission sent to: (if different from above)

Name _____

Address _____

City _____ State _____ Zip _____

This application signed this _____ day of _____, _____ (Year)

By State Licensed Agent _____ Title _____

**PLEASE ENCLOSE A COPY OF AGENT/BROKER LICENSE
IF NOT CURRENTLY ON FILE WITH VSP.**