AVESIS VISION PLANS
AVESIS INSURANCE INCORPORATED

Phoenix, Arizona Policy No. VC-16, 22, 23

APPLICATION FOR AVESIS VISION BENEFITS

I. EMPLOYER INFORMATION

Employer Name: _____ Tax ID# _____

DBA Name (if other than above): _____

Business Address: _____ City _____ State _____ Zip _____

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

Key Contact _____ Title _____

Phone Number ( ) - _____ Fax Number ( ) - _____

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: _____

Separate Billing required? ☐ Yes ☐ No (if yes, please attach names of classifications, location addresses and contact)

ID Cards to be mailed to: ☐ Cardholder ☐ Employer ☐ Avesis

Will this plan replace any existing coverage? ☐ Yes ☐ No If "Yes", indicate name and address of existing insurer

Name: _____ Address _____

City _____ State _____ Zip _____

If "Yes", are any Employees on COBRA continuation?: ☐ Yes ☐ No How Many? _____

Effective date of existing coverage ___/___/___

Termination date of existing coverage (if applicable) ___/___/___

Number of Full-time Employees _____ Number Applying _____

II. PLAN SELECTION

Employer Paid ☐ Voluntary ☐

		Exam	Lenses	Frame	Contact Lenses
☐	AVESIS Advantage Vision Simple Savings Plan				
☐	AVESIS Advantage Vision Basic Plan	12 months,	12 months,	12 months,	12 months
☐	AVESIS Advantage Vision Enhanced Plan	12 months,	12 months,	24 months,	12 months
☐	AVESIS Advantage Vision Plus Plan	12 months,	12 months,	24 months,	24 months
☐	AVESIS Advantage Vision Preferred Plus	12 months,	24 months,	24 months,	24 months
☐	AVESIS Gold	24 months,	24 months,	24 months,	24 months
☐	AVESIS Silver	months	months	months	months
☐	AVESIS Bronze				

Co-payment: ( ) Split $ _____ Examination ( ) Combined $ _____

$ _____ Frame/Lenses ( ) Combined $ _____

	NO. OF EMPLOYEES		RATE		TOTAL REMITTANCE
Employee Only Rate		X	$	=	$
Employee + Spouse		X	$	=	$
Employee Child(ren)		X	$	=	$
Employee + Family		X	$	=	$
	TOTAL			=	$

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, diskette or computer tape.) Premiums shall be payable in advance at the rates set forth in the following Schedule of Premiums.

IV. ELIGIBILITY

PROBATIONARY PERIOD For New Employees: ☐ 30 days ☐ 60 days ☐ 90 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 here, 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 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 **/ /** If insurance is waived or declined for eligible Dependents, then those Dependents will not become eligible again until **/ /**

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 2 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. At least 2 Employees must be covered on the Policy's Effective Date.

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 Employer hereby makes application to Fidelity Security Life Insurance Company for AVESIS 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 _____, **20** _____

Signed for the Employer: _____ Title: _____

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 Checks Payable To: ☐ Firm Name Tax I.D.# _____

Commission Checks Payable To: ☐ Broker Name Social Security **- -** _____

Broker Signature _____ Phone **( ) -** _____

This application signed this _____ day of _____ **,20** _____