EyeMed VISION CARE

Underwritten by Fidelity Security Life Insurance Company

Nat Policy No.

Application for Vision Care 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: _____

Principal Contact: Title: _____

Phone: _____ Fax: _____ E-mail: _____

Type of Business: ☐ Proprietorship ☐ Corporation ☐Partnership ☐ Other (Specify): _____

PLEASE NOTE THE FOLLOWING TYPE BUSINESSES REQUIRE PRIOR CARRIER APPROVAL:
☐ MEWA ☐ PEO ☐Trust ☐ Union

Service Area: ☐ National (US, does not include Puerto Rico) ☐ State Specific (list): _____

Billing Contact Name: Phone: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

If you have subsidiaries, affiliated companies, or divisions who use another name and will be covered by this plan, AND require separate billing invoices, please attach the following information on a separate sheet of paper:
-Name, Address, Billing Contact and Phone Number

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: _____
Address: _____
City: _____ State: _____ Zip: _____

Effective date of existing coverage: _____ Termination date of existing coverage: _____

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

II. PLAN SELECTION

Please refer to the attached proposal page, signed by the client.
Services are provided by EyeMed Vision Care

III. PREMIUMS

Contribution towards premium ☐ Yes ☐ No

Employer's Premium Contribution for: Employees: _____ Dependents: _____

Employee'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

Premiums shall be at the rates set forth in the Schedule of Premiums, included on the attached proposal page.

IV. ELIGIBILITY INFORMATION

Number of Employees: _____ Number Applying: _____ Number Dependents: _____

Are Domestic Partners covered under this plan? ☐ Yes ☐ No

Eligibility Reporting Contact (produces the eligibility file): _____

Address (if different from group): _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Eligibility Authorization Contact (Benefits Administrator or Third Party Administrator responsible for verifying vision elections for members)

Name: _____ Phone: _____

Days/Hours of Availability: _____ E-mail: _____

PROBATIONARY PERIOD

For New Employees: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days ☐ Other _____

Probationary Period is waived for present Employees: ☐ Yes ☐ No

Number of Employees who have not yet completed the probationary period: _____

V. EFFECTIVE DATE

1. This plan will become effective at 12:01 a.m. Standard Time at the employer's address herein, on _____, 20_____ provided that all of the following have been completed prior to this effective date:
   A. This application has been received and accepted by the Company (must be submitted 30 days in advance of the effective date).
   B. EyeMed has been furnished a working file of all eligible members, according to the membership layout guidelines. It is understood and agreed that EyeMed may rely on this information to provide services to individuals designated as eligible.

2. This plan will be effective through _____, 20_____ (_____ months) and the premium is based on the information provided.

The Employer hereby makes application to Fidelity Security Life Insurance Company for Vision Care Benefits. The Employer agrees to maintain and furnish any records necessary to administer the plan, and to forward 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.

☒ Signed for the Employer: _____

Title: _____ Date: _____

VI **MEMBER ID CARDS**

Group will be receiving EyeMed ID cards: ☐ Yes ☐ No

Plan Display Name: _____

(Company Name as you want it to appear on all other correspondence).

Company Name as you want it to appear on the ID card. (Can only be 30 characters including punctuation, spacing & any code)

_____

All EyeMed ID cards are mailed directly to employees' home address

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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 (print): _____ Tax ID Number: _____

Broker Name (print): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Primary Contact: _____ Secondary Contact: _____
Title: _____ Title: _____
Email: _____ Email: _____

☒ Broker Signature: _____

WRITING GENERAL AGENT'S CERTIFYING STATEMENT

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

Firm Name (print): _____ Tax ID Number: _____

General Agent Name (print): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Primary Contact: _____ Secondary Contact: _____
Title: _____ Title: _____
Email: _____ Email: _____

☒ General Agent's Signature: _____