Application for Vision Care Benefits

Underwritten by Fidelity Security Life Insurance Company
Kansas City, Missouri
Policy No. VC-16

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: ______________ E-mail: ______________

(if other than above)
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:

____

____

Are separate billings required? ❒ Yes ❒ No

If "Yes," please attach a separate sheet with classifications, locations, addresses and contacts.

Do you want to be included in the e-billing system? ❒ Yes ❒ No

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 *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**

Plan		Exam	Lenses	Frame	Contact Lenses
❒ 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 Plan	❒	12 months,	24 months,	24 months,	24 months
❒ Other ______________	❒	24 months,	24 months,	24 months,	24 months
	❒	__ 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 $	______	=	$ ______________
			TOTAL	=	$ ______________

III. PREMIUMS

Employee 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

Premium received with application: ____

(Note: Please attach a list of all participants to this application. The list may be a paper copy, diskette, or electronic. Premiums shall be payable in advance {at the rates set forth in the attached proposal page.)

IV. 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, rates are guaranteed 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 forward premiums monthly in advance.

The Employer represents 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 the 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 or she is not at work on such date performing all duties of his or her occupation and otherwise meets the requirements of the Insurance Company.

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 may be guilty of insurance fraud.

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 Check Payable to: ____________________ Firm Name: ____________________ Tax ID#: __________________

Commission Check Payable to: ____________________ Broker Name: __________________ SS#: ____________________

Broker Signature: ____ Phone: ______________________________________

This application signed this __________________ day of ____________________ , 20 __________

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