Application for Avesis Vision Benefits

Underwritten by Fidelity Security Life Insurance Company

Kansas City Missouri

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: ______________________

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: ______________

II. PLAN SECTION

❒ **Employer Paid** ❒ **Voluntary**

			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

Co-payment: **( ) Split** **$ ______ Examination ( ) Combined $ ______**

$ ______ Frames/Lenses ( ) Combined $ ______

	No. of employees		Rate		Total Remittance
Employee Only Rate	________	X	$ ______	=	$ ____________
Employee + Spouse	________	X	$ ______	=	$ ____________
Employee + Children	________	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 (Choose one)

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 his or her 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 decline for eligible Dependents, then those Dependents will 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 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. At least 10 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 ________, 200__ , provided this application shall have been accepted by the Company.

The Policy, if issued, shall be effective for a term of two (2) years.

We wish to be included in the Avesis e-billing system ❐ Yes ❐ No

VI. APPLICATION INSTRUCTIONS

Complete this application form. Be sure to sign at the bottom.

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

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 ________ , 200__________

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 ________________ , 200________