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ESSENTIAL BENEFITS

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: _____
(if other than above)

Key Contact: _____ Title: _____

Phone Number: _____ Fax Number: _____ E-mail: _____

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:

_____

_____

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**

	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: % _____

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 or diskette.)

Premiums shall be payable in advance.

IV. ELIGIBILITY (Choose one)

PROBATIONARY PERIOD FOR NEW EMPLOYEES ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 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 herein, 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 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 the next open enrollment period or _____, if earlier. If insurance is waived or declined for eligible Dependents then those Dependents will not become eligible again until the next open enrollment period or _____, if earlier.

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.

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 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 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 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.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Dated at: _____ this _____ day of _____ , 20 _____

Signed for the Employer: _____ Title: _____

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

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

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