Gerber Life Insurance Company

1311 Mamaroneck Avenue
White Plains, New York 10605

EXCELVISION
SEEING IS BELIEVING

APPLICATION FOR GROUP COVERAGE: VISION

Group Applicant

Full Legal Name of Employer:		SIC:
Group Contact:	E-mail Address:	
Address (Street):		Telephone:
City:	State:	Zip Code:

Legal Entity:
☐ Corporation ☐ S-Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Trust ☐ Association ☐ Other:

Nature of Business:

Subsidiaries or Affiliates to be insured: ☐ No ☐ Yes, Full Legal Name(s):
1.

2.

Group Billing Information (If different from Group Applicant)

Tax ID/FEIN #:

Billing Address:
Street: City: State: Zip:

Billing Contact:		Title:
Telephone:	Fax:	E-mail:

Coverage Requested

1. Plan: ☐ Plan A ☐ Plan B ☐ Plan C
2. Contribution: ☐ Employer Paid ☐ Voluntary
3. Section 125: ☐ Yes ☐ No

2. Requested Effective Date:

3. Number of Eligible Employees:	4. Number of Employees enrolling:
5. Number of Eligible Dependents:	6. Number of Dependents enrolling:

7. Waiting Period: Initial Employees: ☐ None ☐ Other:
Future Employees: ☐ One Month ☐ Other:

8. All or part of this insurance will replace similar coverage:
☐ No ☐ Yes, please submit copies of the policy(ies) and/or certificate(s)
How many are currently on COBRA continuation?

Prior Carrier	Coverage	Effective Date Termination Date:

9. Initial premium deposit: Minimum First Month Premium, Plus $ 10.00 Monthly Billing Fee.

TOTAL REMITTED: $ _____

Eligibility

Indicate the Number of Eligible Employees and the Number of Employees Initially Insured:

Plans *(See Proposal for Benefit Frequency and Allowances)*	**Copayment/ Deductible**	**Number of Eligible Employees**	**Number of Enrollment Forms**
☐ Plan A	$10 Exam $10 Materials		
☐ Plan B	$10 Exam $25 Materials		
☐ Plan C	$15 Exam $30 Materials		

Deliver Administration Package to: ☐ Group ☐ Broker/Agent ☐ Authorized Representative

Eligible Persons:

Minimum Participation Requirement:

Employer Paid: 75 - 100% employer contribution for both employees & dependents. At least 75% participation of eligible employees

Voluntary: 0 - 49% employer contribution for employees. No employer contribution requirements for dependents. Minimum 2 to enroll.

If this insurance applied for is a replacement of existing insurance, are you the same broker/agent who previously wrote the case?
☐ Yes ☐ No

Rates (Please attach a copy of the proposal and rates.)

Policyholder Plan Options:

100% Employer Paid:	**Plan A**	**Plan B**	**Plan C**
Exam/Lenses/Frames	12/12/12	12/12/24	12/12/24
Copay Exam/Materials	$10/$10	$10/$25	$15/$30
Employee	$7.74	$6.00	$5.18
Employee + Spouse	$13.16	$9.97	$8.82
Employee + Child(ren)	$13.55	$10.27	$9.08
Employee + Family	$19.35	$14.67	$12.97
Voluntary: Min 2 Enrolled:	**Plan A**	**Plan B**	**Plan C**
Exam/Lenses/Frames	12/12/12	12/12/24	12/12/24
Copay Exam/Materials	$10/$10	$10/$25	$15/$30
Employee	$10.13	$6.69	$6.06
Employee + Spouse	$19.74	$12.98	$11.81
Employee + Child(ren)	$20.75	$13.71	$12.42
Employee + Family	$28.85	$19.06	$17.26

Employer Contribution Amount, Employee: $ _____ , _____%
Employer Contribution Amount, Dependents: $ _____ , _____%

Agreement and Authorization

It is agreed that the policy will not become effective unless the application is approved by the Company at its Home Office at rates to be determined by the Company. The Premium Deposit will be refunded if the application is not approved by the Company. If approved, the effective date of the policy will be: (a) the effective date requested; or (b) the date the required number of Employees who are to contribute to the Cost of the Group Insurance have enrolled, whichever is later. The Applicant declares that to the best of his knowledge and belief, the statements and answers to the above questions are complete and true.

NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Dated at: (City) (State)	This (Month) (Day) (Year)
Print Name:	By (Authorized Signature)

Broker/Agent Statement & Information

I hereby certify that all the information contained in this Application for Group Insurance is correct and I know nothing unfavorable about this entity or any individual proposed for the insurance. I have complied with underwriting rules and regulations and have explained in detail the coverages to the entity and its employees.

Broker/Agent Name (Printed)	Telephone	Fax No.
Company Name	Tax ID No.	State Insurance License No.
Broker/Agent Street Address (PO Box not acceptable)	Broker/Agent E-mail Address:	
City:	State:	Zip:
General Broker/Agent (If Applicable)	Telephone	Fax No.

This form along with the enrollment cards and first two (2) month's premium should be submitted to the local representative.

BROKER/AGENT SIGNATURE: _____DATE: _____

PRINT NAME: _____