OPTIPLUS VISION PLAN
A PGP VOLUNTARY VISION PROGRAM

EMPLOYER APPLICATION

Company Name _____

Address _____

City _____ State _____ Zip _____

Contact Person _____ Phone _____ Fax _____

E-Mail address _____ Nature of Business _____

Effective Date of Coverage _____/_____/_____ Note***: Effective Date Of Coverage Must Be First Day Of The Month.***

PREMIUM AND ENROLLMENT INFORMATION

Number Of Employees Enrolling In Plan _____

PGP Voluntary Vision Program

	Enrolling		Rate	Subtotal
Single	_____	X	$9.60 =	$_____
Two Party	_____	X	$15.25 =	$_____
Family	_____	X	$23.83 =	$_____
			Monthly Total =	$_____

MAKE CHECK PAYABLE TO: Professional Group Plans

WAITING PERIOD

New Employees	☐ 0 days	☐ 30 days	☐ 60 days	☐ 90 days	☐ Other _____ Days

Important Note: Coverage For New Hires Begins The First Of The Month Following The Waiting Period

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially 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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

SIGNATURE OF OFFICER	TITLE	DATE
X_____	_____	_____/ _____/ _____

Policy # _____ (For Professional Group Plans Use Only)

BROKER INFORMATION

Broker of Record _____ General Agent _____

Broker Name _____

Company Name _____

Address _____ City _____ State _____ Zip _____

Phone (____)_____ Fax (____)_____ Email Address _____

Broker email address _____ ☐

Social Security # _____ or Tax ID # _____ **Include Copy Of Current License**