APPLICATION FOR VISION CARE PLAN (sm)

PROFESSIONAL GROUP PLANS

P.O. Box 997100 • Sacramento • California 95899-7100

(800) 852-7600
Attn: Tina Hemphill

Mail Applications to:

225 Wireless Blvd, Suite 200
Hauppauge, NY 11788

Complete all applicable questions accurately and in detail.

CLIENT INFORMATION

1 Full legal name of client as it appears on the policy:

Address:

City: County: State: ZIP:

Phone: Fax: E-mail:

Principal Contact: Title:

Phone: Fax: E-mail:

Client is headquartered in state of (if different from above)

2 Who should we contact with payment questions?

Name: Title:

Phone: Fax: E-mail:

3 Who should we contact with eligibility questions?

Name: Title:

Phone: Fax: E-mail:

4 Who is the Benefit Administrator responsible for the overall administration of the plan (if not principal contact)?

Name: Title:

Phone: Fax: E-mail:

If multiple benefits administrators are at other locations, attach list of names, addresses, phone, and fax numbers.

5 Standard Industry Code (SIC): Division: Major Group:

What is the nature of your business?

6 Membership updates will be made via a secure Internet site. Do you have Internet access? yes☐ no☐

Membership information will be sent to VSP on [ ] (date).

Employers without Internet access for making membership updates will be contacted by VSP to review other options.

7 Names of separate divisions that will be covered by this plan:

Will a separate billing be needed for the above divisions? yes☐ no☐

Billing address (if applicable):

Firm/Organization:

Address:

City: County: State: ZIP:

Phone: Fax: E-mail:

If Self-Funded Program, do claims billings and administrative fee billings go to the same person? yes☐ no☐
If no, please supply contact, title, address, phone, and fax number for each type of billing.

8 Send employee benefit information* to (select one):
Client's Benefit Administrator☐ Third Party Administrator☐ Broker/Consultant☐ Other☐-please specify:

** Any non-VSP-created information outlining coverage or plan details must be reviewed by VSP prior to distribution to members.*

9 Number of employees eligible for benefits:

Does this represent the total number of employees in the company? yes☐ no☐ total number:

Do you have employees in Canada? yes☐ no☐

Do you provide benefits to your retiree population? yes☐ no☐

10 Dependents: Eligible dependents are the covered employee's spouse and unmarried dependent children until the end of the month that they reach their [ ] birthday (includes an unmarried child if incapable of self-support because of physical or mental incapacity that commenced prior to reaching the above age), or the end of the month that they reach their [ ] birthday, if attending school full time.

Dependents other than employee's spouse & children:

parents☐ domestic partners (all)☐

domestic partners (same sex only)☐ domestic partner's children☐

11 Third party administrator (if applicable): Firm:

Address:

City: County: State: ZIP:

Phone: Fax: E-mail:

Name: Title:

POLICY DETAILS

The rates listed must support the plan design and benefit selected and must meet all eligibility requirements.
Please refer to your VSP-provided rate sheet for details or contact your VSP Account Executive.
Any discrepancies may preclude acceptance by VSP.

12 Benefit Year (select one):

Service Year (from last date of service)☐

Calendar Year (January 1 effective dates only)☐

Plan Year (from effective date of contract)☐

13 Plan Type (select one):

VSP Signature Plan☐

VSP Choice Plan☐

Exam Plus☐

Exam Plus w/ Allowances☐

14 Is vision benefit: Core☐ Voluntary☐ Packaged with medical and/or dental☐

If Voluntary (vision is included as a stand-alone menu item in a list of benefits to choose from.):

Employer contribution percentage: for employee: % for dependent: %

If Core Plus Options (group provides a basic level of vision coverage to all employees with an option for the employee to buy up or enhance the benefit):

Employer contribution percentage: for employee: % for dependent: %

If Packaged (vision is tied to which of the following benefits: medical☐ dental☐

Employer contribution percentage: for employee: % for dependent: %

Voluntary Participation Structure: *A minimum number of enrolled employees may apply.

Exam w/Voluntary Materials*☐ Voluntary Pool 0-24% employer contribution*☐

Voluntary Pool 25% or more employer contribution*☐ Core Employee/Voluntary Dependent Coverage*☐

15 Frequency of Service (select one):

A (12/24/24)☐ B (12/12/24)☐ C (12/12/12)☐

Other☐ :

Total co-payment: $ (applies to exam and eyewear)

OR Split co-payment: $ exam / $ eyewear

16 Client has purchased Enhancements or Specialty Care: yes☐ no☐

☐ Covered Contact Lenses	☐ ProTec Safety	☐ Scratch Coating
☐ Second Pair of Glasses	☐ Computer Vision Care	☐ Anti-Reflective Coating
☐ Vision Therapy	☐ Preferred Laser VisionCare (available on a self-funded basis only to clients with 200+ enrolled employees)	☐ Progressive Lenses
☐ Primary Eyecare		

Elective Contact Lens Buy-up (Allowance): $140☐ $150☐

Frame Buy-up (Retail Frame Allowance): $140☐ $150☐ other☐ $

17 Requested effective date *(The effective date should not precede the date VSP receives this application.)*

This policy will become effective on the first day of [ ] (month) [ ] (year), provided that all of the following has been completed prior to this effective date:

A. VSP has received and accepted this Application.

B. VSP has received and accepted Membership, including the required information of all employees that will be covered under this policy showing name, member ID, and number of dependents, if applicable.

18 This agreement will continue in force 24 months from the effective date. Rates are based on the assumption that VSP will receive these amounts over the full plan term.

19 5500 Report Information: Fiscal Year [ ] through [ ].
5500 Report will be sent to the person named as the principal contact. A copy of the report may also be sent to your broker and/or your third party administrator.

Please send an additional copy to:

20 Prior VSP coverage: yes☐ no☐ If yes, prior client name:

21 Names of affiliates or subsidiaries with VSP coverage under a separate contract:

22 *For fully-insured programs (VSP will bill you for your first month's premium)*

	# of Employees	x Rates
Employee-only or composite rate basis	[ ]	x $
Two, Three- or Four-rate basis	[ ]	x $
	[ ]	x $
	[ ]	x $
	[ ]	x $

23 *For self-insured programs*, Administrative Fee:

Fixed fee:

or Percent of claims: %

or Dollars per claims: $

AGREEMENT

The undersigned client hereby applies for vision care coverage through VSP.

It is understood that:

A. All future employees will be covered when they become eligible, or offered VSP coverage if voluntary.

B. Coverage will terminate for an employee on the last day of the month in which employment terminates.

C. Member past service for clients previously covered by VSP will carry over and remain in force.

D. This agreement will continue in force 24 months from the effective date. Rates are based on the assumption that VSP will receive these amounts over the full plan term.

This application signed this [ ] (day) of [ ] (month) of [ ] (year).

Firm/Organization:

Name: Title:

Signature:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.

BROKER / CONSULTANT

☐ The broker/consultant indicated below is hereby designated Broker of Record by the above signed employer.

Legal Firm Name:

Address:

City: County: State: ZIP:

Licensed Producer's Name: Title:

Phone: Fax: E-mail:

Broker Assistant Name: E-mail:

Taxpayer ID: Corporation☐ Independent☐

Commission Checks Payable to:
Firm Name☐
Contact Name☐
Not Paid☐

Name:

Address:

City: County: State: ZIP:

This application signed this [ ] (day) of [ ] (month) of [ ] (year).

Name: Title:

Signature of state-licensed agent:

Please send a copy of agent/broker license, if not currently on file with VSP.

GENERAL AGENT

Legal Firm Name:

Address:

City: County: State: ZIP:

Licensed Producer's Name: Title:

Phone: Fax: E-mail:

Broker Assistant Name: E-mail:

Taxpayer ID: Corporation☐ Independent☐

Commission Checks Payable to:
Firm Name☐
Contact Name☐
Not Paid☐

Name:

Address:

City: County: State: ZIP:

This application signed this [ ] (day) of [ ] (month) of [ ] (year).

Name: Title:

Signature of state-licensed agent:

Please send a copy of agent/broker license, if not currently on file with VSP.