

APPLICATION FOR GROUP VISION CARE PLAN



VSP
P.O. Box 997100 • Sacramento • California 95899-7100
(800) 852-7600
Attn: Sales Mailstop 315

All applicable questions must be completed accurately and in detail to avoid delay.
Please type or print all information.

GROUP INFORMATION

1. Full legal name of group as it appears on the policy: _____
Address _____
City _____ County _____ State _____ Zip _____
Telephone (_____) _____ Fax (_____) _____
Principal Contact _____ Title _____ E-mail _____
2. Who should we call with payment questions? _____ Title _____
Telephone (_____) _____ Fax (_____) _____ E-mail: _____
3. Who should we call with eligibility questions? _____ Title _____
Telephone (_____) _____ Fax (_____) _____ E-mail: _____
How would you like your Eligibility contact to be notified of eligibility rejections? (Please include number)
 Fax _____ Telephone _____
4. Is someone other than the principal contact responsible for the overall administration of the plan (benefits administrator)?
Name _____ Title _____
Telephone (_____) _____ Ext. _____ Fax (_____) _____
If multiple benefits administrators are at other locations, please attach separate piece of paper, with name(s), address(es), telephone, and fax numbers.
5. What is your Standard Industry Code (SIC)? _____
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
Employers without Internet access for making membership updates will be contacted by VSP to review other options.
- 7a. Names of separate divisions that will be covered by this plan:
NAME

GROUP INFORMATION CONTINUED

- 7b. Will a separate billing be needed for the above divisions? Yes No
Billing address (if applicable):
Firm/Organization _____
Address _____
City _____ State _____ Zip _____
Telephone (_____) _____ Fax (_____) _____ E-mail: _____
- 7c. 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, telephone, and fax number for each type of billing.)
- 7d. Are you covering any members over the age of 65, who are also covered under Medicare? Yes No
(If yes, to comply with Medicare regulations, a separate division is needed to ensure coordination of benefits are applied correctly)
8. Send employee benefit information* to: Group's Benefit Administrator Third Party Administrator Broker/Consultant
**Any non-VSP-created information outlining coverage or plan details must be reviewed by VSP prior to distribution to members.*
9. Eligibility rules for covered employees: (Any exclusions must be based upon conditions pertaining to employment.)
 Full-time employees
 Other (describe in detail) _____
10. Waiting period: New employees will be eligible on the first day of the calendar month following _____ complete month(s) of continuous full-time employment.
 Other (describe in detail) _____
11. Total number of all covered employees _____
Does this represent the total number of employees (full-time and part-time) in the company? Yes No
12. Dependents: Eligible dependents are the covered employee's spouse and unmarried dependent children until they reach their _____ birthday (also includes an unmarried child if incapable of self-support because of physical or mental incapacity that commenced prior to reaching the above age), or their _____ birthday, if attending school full-time.
Dependents other than employee's children: parents domestic partners (all) domestic partners (same sex only)
 domestic partner's children
13. The third party administrator (if applicable):
Firm _____
Address _____ E-mail _____
City _____ State _____ Zip _____
Telephone (_____) _____ Fax (_____) _____
Contact _____ Title _____

POLICY DETAILS

14. Service Year: (Select One)
 Service Year *(from last date of service)*
 Calendar Year *(available for groups with January 1 effective dates only)*
15. Is Vision packaged with Medical Dental Other
16. Plan Type: Standard Plan Exam Plus Plan Exam Plus w/Allowances Plan Value Plan
 Exam w/Voluntary Materials Plan *(available only for groups with 200+ ees)*
17. Frequency of Service: A (12/24/24) B (12/12/24) C (12/12/12) Other _____
Co-Payment: \$ _____ Total co-payment (applies to exam and eyewear) **OR** Split \$ _____ Exam/\$ _____ Eyewear

POLICY DETAILS CONTINUED

18. Group has purchased **Enhancements or Specialty Care:** Yes No
 Covered Contact Lenses Second Pair of Glasses Vision Therapy Primary Eyecare
 Safety EyeCare Computer VisionCare Preferred Laser VisionCare
 (only available to self-funded clients with 200 or more employees)

Frequency of Service: Exam ____ months; Lenses ____ months; Frame ____ months Co-Payment \$ _____
 Frequency of Service: Exam ____ months; Lenses ____ months; Frame ____ months Co-Payment \$ _____

19. **FOR FULLY INSURED PROGRAMS:**

First month's premium remittance calculation:

	EMPLOYEES	RATE	TOTAL REMITTANCE
Employee only or composite	_____ x	\$ _____ =	\$ _____
Two, Three or Four-rate basis	_____ x	\$ _____ =	\$ _____
	_____ x	\$ _____ =	\$ _____
	_____ x	\$ _____ =	\$ _____
		TOTAL =	\$ _____

20. **FOR SELF-INSURED PROGRAMS:**

Administrative Fee: Fixed fee _____ or Percent of claims _____
 Prefunding (Advance Payment): Amount if Group is an Administrative Service Program
 \$ _____ (per covered employee - as quoted) x _____ = \$ _____
 (number of employees)

21. Requested effective date (*The effective date should not precede date of receipt of this application by VSP.*)

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

- A. Application has been received and accepted by VSP.
- B. VSP has been furnished the required information of all employees that will be covered under this policy showing name, Social Security number, and number of dependents, if applicable.

22. 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. Financial penalties may apply in the event of early termination of the contract.

23. 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: _____

24. Prior VSP coverage: Yes No
 If yes, prior group name _____
 Was prior group coverage HMO Plan Association Union Other _____

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

26. The plan (will will not) be offered under § 125 of the Internal Revenue Code.

27. § 125: Percentage of premiums to be contributed by employer for **employees** _____.
 Percentage of premiums to be contributed by employer for **dependents** _____.
 Other _____

AGREEMENT

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

It is understood that:

- A. The group will cover all employees specified under Item 11 and pay 100 percent of the cost (if §125: _____ percent of cost).
- B. All future employees will be covered when they become eligible.
- C. Coverage will terminate for an employee on the last day of the month in which employment terminates.
- D. Member past service for groups previously covered by VSP will carry over and remain in force.
- E. 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. Financial penalties may apply in the event of early termination of the contract.

This application signed this _____ day of _____, _____
Firm/Organization _____ (Year)

By _____ Title _____

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.

(Please Print)

Firm Name _____

Address _____

City _____ County _____ State _____ Zip _____

Telephone (_____) _____ Fax (_____) _____

Contact _____ Title _____ E-mail _____

Taxpayer I.D. # _____

Commission Checks Payable to: Firm Name Contact Name Not Paid

This application signed this _____ day of _____, _____
(Year)

By State Licensed Agent _____ Title _____

**PLEASE ENCLOSE A COPY OF AGENT/BROKER LICENSE
IF NOT CURRENTLY ON FILE WITH VSP.**