Supplemental Vision Benefit Employer Trust (SVBET)

Underwritten by Vision Service Plan

Checklist, Employer Application and List Enrollment Form

Employer Groups with 3+ employees

This checklist will assist you in submitting the necessary forms so that we may process your application.
Incomplete applications will be returned for completion, which may result in a later effective date than requested.

□ Checklist
□ Employer Application, signed by the employer/plan sponsor and the agent
□ List Enrollment Form(s)
□ If electing Participation Option 1, please submit a copy of the current medical bill (or current medical applications)
□ If electing Participation Option 2, please submit a copy of the current dental bill (or current dental applications)
□ If electing Participation Option 3 or 4, please submit a copy of most current Quarterly Wage Report (reconciled)
□ If you have Federal COBRA or State Continuation of Benefits participants, you must include a copy of their original election form at time of enrollment
□ Copy of agent's current license
□ Copy of Warner Pacific's proposed rates
□ First month's premium check, made payable to "Beneficial Administration, LLC"
□ All forms must be received by the Warner Pacific Underwriting Department prior to the requested effective date. Groups received after that time are not guaranteed the requested effective date.

Eligibility Guidelines:

- This is not a voluntary plan. The group must meet participation requirements at all times.
- A minimum of three employees must be enrolled at all times.
- *Enrollment in this plan is determined by the employer's participation selection.*
- Renewals occur every January, regardless of the employer's original effective date.
- An eligible employee is defined as an employee working full-time, 30 hours or more per week.
- Part-time employees, working 20-29 hours per week, may be covered if employer chooses, or if matching the medical or dental participation option as long as there are three full time employees enrolled.
- All eligible employees and their eligible dependents must be added to the plan as soon as the group waiting period has been met.
- There is no open enrollment period. All eligible employees and dependents must enroll at initial enrollment or within 30 days of a qualifying event. A qualifying event is defined as: adoption, marriage, or birth of newborn.
- An eligible dependent is an employee's spouse/domestic partner and any child of the enrolled applicant or spouse/domestic partner who is under age 26. It is the employee's responsibility to inform the group administrator of any change in status of his/her dependents.
- These plans are only available to groups headquartered in the following states: CA, CO, GA, IA, IL, IN, KS, MI, MN MO, NC, NJ, NV, OH, OK, SC, TN, TX and WV. Employees can live in any of the 50 states.

Contacts:

Agent Presentation by:
Warner Pacific Insurance Services
32110 Agoura Road
Westlake Village, CA 91361-4026
Phone: (800) 801-2300
Fax: (800) 609-0111
www.warnerpacific.com

Group Administration & Billing:
Beneficial Administration, LLC
P.O. Box 3100
Newport Beach, CA 92658-9027
Phone: (866) 706-2225
Fax: (949) 724-1603
www.beneficialadmin.com

Member Customer Service & Claims:
Vision Service Plan
P.O. Box 997100
Sacramento, CA 95899-7100
Phone: (800) 877-7195
www.vsp.com

Please call Warner Pacific Insurance Services, Inc., if you have any questions about submitting a new group enrollment.
Post-enrollment eligibility questions should be directed to Beneficial Administration, LLC.

Supplemental Vision Benefit Employer Trust (SVBET)
EMPLOYER VISION APPLICATION

Requested Effective Date (first of month only): _____/______/______

(Actual effective date will be determined by Beneficial Administrative, LLC if application is accepted.)

1. **Employer Information:** The employer certifies that the following information is correct:

Company Name:____

Street Address (not P. O. Box): ____

City:______________________________________ State:____________Zip:________________

Billing Address (if different from Street Address): __________________________

City: ______________________________________ State:______________ Zip:______________

Employer is a: ☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Other (please explain): ____________

Tax I.D. Number: ______________________ Company Contact Person: ______________________

Email Address: ________________________Telephone:______________ Fax: _________________

Date Business was established: ___/_____/_______ Type of Business (be specific): ____________________

Total number of employees on payroll including owners/officers: _____ Is the company subject to Federal COBRA? ☐ Yes ☐ No

If yes, does your State offer State Continuation after the 18 months of Federal COBRA? ☐ Yes ☐ No

If no, does your State offer State Continuation? ☐ Yes ☐ No

Please note: Because VSP is a multi-state, national carrier, if the employer is subject to state continuation, it is the employer's responsibility to request specific State Continuation of Coverage based on that state's guidelines. The employer must also provide the last known address of the COBRA insured.

2. **Benefit Selection** **(Choose One Plan)**

Signature Plan **(Standard Network)**
- ☐ Plan A (12/24/24) w/$10 Deductible
- ☐ Plan A (12/24/24) w/$25 Deductible
- ☐ Plan B (12/12/24) w/$10 Deductible
- ☐ Plan B (12/12/24) w/$25 Deductible
- ☐ Plan C (12/12/12) w/$10 Deductible
- ☐ Plan C (12/12/12) w/$25 Deductible

Choice Plan **(Open Access Network)**
- ☐ Plan A (12/24/24) w/$0 Deductible
- ☐ Plan B (12/12/24) w/$0 Deductible

3. **Premium Calculation**

	# of Members		Rate		
Employee Only		**X**	$	=	**$**
Employee + 1 dependent		**X**	$	=	**$**
Employee + 2 or more children		**X**	$	=	**$**
Family		**X**	$	=	**$**
			Subtotal		**$**
			Monthly Administration Fee	+	**$15.00**
			Grand Total	=	**$**

4a. Participation Options (Choose One)

☐ 1. VSP participation and contribution matches the Employer-Sponsored medical plan participation exactly. All eligible employees and dependents must be enrolled continuously under both plans to remain eligible under the vision program.
Name of the medical carrier that participation will match ______________________________.

☐ 2. VSP participation and contribution matches Employer-Sponsored dental plan participation exactly. All eligible employees and dependents must be enrolled continuously under both plans to remain eligible under vision program.
Name of the dental carrier that participation will match ______________________________.

☐ 3. VSP contribution is 100% Employer-paid and all eligible employees and dependents must enroll (100% participation).

☐ 4. VSP contribution is 100% Employer-paid and all eligible employees (100% participation) must enroll. No dependent coverage is offered.

4b. Employee Eligibility (Choose One)

The waiting period for vision benefit plan participation for future employees is first of the month following:

☐ Date of Hire ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months

Are you waiving the waiting period for new hires at initial enrollment?	☐ Yes	☐ No
Are you acquiring new medical/dental coverage at the same time?	☐ Yes	☐ No
Do you have employees currently on COBRA or State Continuation?	☐ Yes	☐ No
Do you have employees in their COBRA or State Continuation election period?	☐ Yes	☐ No

If there are employee(s) within their election period, please list them below.

______________________ ______________________ ______________________

5. Participation Agreement

We, the undersigned group understand that we are applying for membership in the Supplemental Vision Benefit Employer Trust ("Trust"). Vision Service Plan ("VSP") has issued a master policy to the Trust which provides vision benefits to employer groups and their eligible employees and dependents. We certify that all information provided with respect to the company and its employees/members is accurate and complete. If not complete, VSP and/or Beneficial Administration, LLC reserve the right to reject this application.

We, the undersigned group, understand that we have an obligation to ensure that all persons offered benefits meet eligibility requirements and that coverage is offered to every eligible person. We understand that we will be liable for any claims incurred during any period in which we do not meet the participation and eligibility maintenance requirements. We understand that VSP and/or Beneficial Administration, LLC will rely on the representations contained in this document and any others, such as applications, which we provide in determining whether they will accept us as an eligible group.

It is understood that coverage for any benefits shall not commence until a completed Employer Application has been approved by VSP and/or Beneficial Administration, LLC, its authorized agents, or representatives; the first month's premium for the vision benefit plan has been paid; all completed employee applications have been submitted; and notice of said approval has been transmitted in writing to us. We certify that the answers on any and all applications are true and understand that coverage may be rescinded should it be determined at a future date that there are misstatements in the applications.

Some of the contracts Vision Service Plan holds with Warner Pacific Insurance Services ("Warner Pacific") provide for payment of incentives, compensation, excess surplus and bonuses ("compensation"). In the sole and exclusive discretion of Warner Pacific, such compensation may be retained by Warner Pacific or distributed to other parties. Such compensation will not be returned to you as the employer/plan sponsor. Any vision benefits claims submitted under your policy/certificate will be paid without regard to such compensation.

Arbitration Agreement: We understand that any dispute between us and VSP, Warner Pacific and/or Beneficial Administration, LLC must be resolved through binding arbitration if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court and not by lawsuit or court process, except as California provides for judicial review of arbitration proceedings.

______________________________ ______________________________
(Signature of Company Officer/Owner) (Printed Name of Company Officer/Owner)

Title______________________________ Date ______________________________

6. Agent's Certification

I hereby certify that I am not aware of any information that has been withheld from this application by the client and which may have bearing on this risk. I hereby certify that I have advised the client not to terminate any existing coverage until they have received written notification from VSP and/or Beneficial Administration, LLC that the coverage being requested by this application is accepted.

Writing Agent's Name (Print or type):______________________________

Agency Name: ______________________________

Street Address: ______________________________

City: ______________________________ State: ____________ Zip: ______________________

Telephone: ______________ Fax:______________________Email: ______________________

Make commission checks payable to Agent or Agency? ______________ SSN or Tax ID Number:______________________

Agent Signature: ______________________________ Date: ______________________

Supplemental Vision Benefit Employer Trust (SVBET)

Vision List Enrollment Form (for initial enrollment)

Group Name: ______________________________

Employee Name (Last Name, First Name)	Social Security Number	Date of Birth	Gender M/F	Date of Full Time Employment	Dependents to be Enrolled		COBRA or State Continuation? Y or N
					Spouse or Domestic Partner (Y/N)	# of Children < age 26	
Smith, Todd **(sample)**	*987-65-4321*	*12/19/59*	*M*	*11/03/88*	Y	2	N
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Please make blank copies of this page for additional employees.