

Supplement Benefit Employer Trust

EMPLOYER VISION APPLICATION

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

(Actual effective date will be assigned by Beneficial Administration 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: _____

Telephone: _____ Fax: _____

Email Address: _____

Date Business was established: _____ / _____ / _____

Type of Business (be specific): _____

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

Value Plan (Select 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	=	\$

4. Employee Eligibility (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.

The waiting period for future employees is first of the month following: (Choose one)

- 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 COBRA employees? Yes No
 Do you have employees in their COBRA election period? Yes No

If so, please list their names and provide us with a copy of their COBRA election form and VSP application at this initial enrollment.

5. Participation Agreement

We, the undersigned group understand that we are applying for membership in the Supplemental 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 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 maintenance requirements. We understand that VSP and/or Beneficial will rely on the representations contained in this document and any others, such as applications, which we provide in determining whether to 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, its authorized agents, or representatives; the first month's premium for the 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 Warner Pacific Insurance Services Inc. ("Warner Pacific") holds with insurance carriers 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 and/or Beneficial 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 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: _____