EMPLOYER APPLICATION FOR GROUP VISION INSURANCE

visionbydesign

Companion Life Insurance Company • PO Box 100102 • Columbia, South Carolina 29202-3102

FAX (803) 735-0736
1-800-753-0404

Please Print or Type

EMPLOYER INFORMATION

1. Full legal name of applicant (As it should appear in policy) — Telephone Number ( )

2. Applicant's Federal Tax ID Number

3. Address — Street — Post Office Box

City — County — State — Zip

4. Administrative Correspondence with the Applicant should be addressed to:
   Name ______ Title ______
   Fax Number ______ E-mail Address ______

5. Nature of Business

6. Requested Effective Date:

7. Are there subsidiary businesses covered under this plan? ☐ Yes ☐ No
   If YES, please state name and nature of each subsidiary or affiliate.

   Are separate billings required? ☐ Yes ☐ No
   If YES, please provide billing instructions.

8. Type of Administration: ☐ Home Office Administered ☐ Self Administered

EMPLOYEE ELIGIBILITY

9. The normal work week for full-time employees is:____ hours. The normal work week for full-time employees must be at least 30 hours. Employees working less than 30 hours per week may be acceptable. Contact Companion Life for approval.

10. Current eligible employees are to be covered:
    ☐ Immediately on the requested effective date.
    ☐ After _____ days of continuous employment.
    ☐ First of the month following ____ days of continuous employment.

11. Employees hired after the plan effective dates are to be covered:
    ☐ Immediately.
    ☐ After _____ days of continuous employment.
    ☐ First of the month following ____ days of continuous employment.

12. Coverage following completion of the waiting period selected will be effective the first of the month following completion of the waiting period or the next billing date.

SPECIFICATIONS FOR INSURANCE

13. Will this coverage replace any existing vision insurance plan? ☐ Yes ☐ No
    If YES, name present insurance carrier:

14. Existing Plan Effective Date:

15. Termination Date of Existing Plan

Select Your visionbydesign Program on the reverse side.

16. **Choose Benefit Design and Options** (Required)

☐ Visions Essentials Plan (Exam Only + Discount)	☐ Vision Choice Plan (Eyewear Only + Discount)	☐ Vision Select Plan (Exam + Eyewear + Discount)
Exam Copay: ☐ $0 ☐ $10 ☐ $20 Exam Frequency: 12 months	N/A	Exam/Lens Copays: ☐ $0/0 ☐ $10/$10 ☐ $20/$20 Exam Frequency: 12 months
N/A	Eyewear Allowances: ☐ $100 Frame/$115 Contacts ☐ $130 Frame/$130 Contacts Frames Frequency: ☐ 12 months ☐ 24 months Lens/Contact Lens Frequency: 12 months	Eyewear Allowances: ☐ $100 Frame/$80 Contacts ☐ $130 Frame/$120 Contacts Frames Frequency: ☐ 12 months ☐ 24 months Lens/Contact Frequency: 12 months

17. **Choose Premium Rate Structure** (Required) ☐ Two Tier ☐ Three Tier ☐ Four Tier
(If sold with Dental, Vision and Dental must have the same premium rate structure)

18. Number of Eligible Employees: ____________________ 19. Number of Enrolled Employees: ____________________

20. Percent of Premium Paid by Employer: ☐ Single/Employee Only ________% ☐ Family/Dependents ________%

21. **Special Vision Product Pricing:** If employee contributions are involved, Companion Life offers special Vision Plan premium rates for employer groups offering a Companion Life Vision plan along with a Companion Life Group Dental Insurance plan. To qualify for these special Vision Plan rates, 100% of those enrolled in the Group Dental plan must also participate in the Vision plan.

a. Will employees contribute to the cost of the Vision plan? ☐ Yes ☐ No

b. Will this Vision Plan be enrolled with a Companion Group Dental Insurance plan? ☐ Yes ☐ No

c. If yes, will 100% of the employees and dependents enrolled in the Companion Life Group Dental plan be required to take the Vision Plan?
☐ Yes ☐ No

EMPLOYER'S SIGNATURE

FRAUD WARNING (Not Applicable in AZ, FL, MD, OR, VA): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal and civil penalties.

FRAUD WARNING (FL only): 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.

Quotations were based on the proposal data submitted to Companion Life. Final premium rates will be determined on the basis of the actual composition of the group of persons who become insured.

If the initial deposit is at least equal to the first month's premium, and if the requested insurance is acceptable under Companion Life's current rules and practices, insurance under the terms of the policy shall be effective on the effective date requested. Otherwise, insurance will become effective only when a policy is delivered and accepted in writing; in the interim, liability is limited to a return of the original deposit. Only Companion Life's Home Office has the authority to guarantee the acceptability of the requested insurance.

Dated at ______________________________ this ____________ day of ____________________, 20 __________
City/State

______________________________ ______________________ ______________________
Signature of Employer Title Witness

AGENT'S REPORT

25. Initial Deposit (Minimum first month's premium is required.)
$

26. Agent/Broker Name (Please Print) Telephone Number
( )

27. Address Post Office Box

City County State Zip

28. Are there other group insurance plans which duplicate any of the benefits applied for with this application that will remain in force or be placed concurrently with this plan(s)? ☐ Yes ☐ No If YES, please describe the benefit amounts and purposes of these plans:

29. Is Agent or Broker licensed and appointed by Companion for the types of insurance solicited where this group is located? ☐ Yes ☐ No
Agent Code Number State License

30. Signature of Agent/Broker ______________________________ Date ____________