VISION EMPLOYER PARTICIPATION APPLICATION FOR THE JOINT EMPLOYER GROUP INSURANCE TRUST

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? If YES, please state name and nature of each subsidiary or affiliate.
   ☐ Yes ☐ No

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

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? If YES, name present insurance carrier:
   ☐ Yes ☐ No

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)

☐ Vision 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

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 decieve 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.

Participation Agreement (Administered and underwritten by Companion Life Insurance Company)

The Employer hereby applies for Group Insurance Benefits as set forth in the above "Vision by Design" Employer Participation Application for the Joint Employer Group Insurance Trust and subscribes to the Agreement and Declaration of Trust.

Name of Trust: The Joint Employer Group Insurance Trust

It is understood and agreed by the undersigned that the Trustee is not an insurer, nor does the Trustee have any obligation under any policy of insurance and that all claims for the benefits provided by insurance being applied for herein shall be made to and payable by the Insurance Companies issuing group policy(ies) to the Trustees, but only to the extent and in strict accordance with the provisions of such policy(ies). The Trust agreement and the group policy(ies) held by the Trustee are available for inspection during regular business hours by the Participant at the office of the Administrator, Companion Life Insurance Company, located at 7909 Parklane Road, Suite 200, Columbia, SC 29223-5666.

_____
(Signature of Employer/Applicant))

_____
(Title) (Date)

_____
(Signature of Resident Agent/Broker))

_____
Print Agent's/Broker's Name License No.

HOME OFFICE USE ONLY Employer Group No.:_____

Accepted by Companion Life Effective: _____

By: _____
(Title) (Date)