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APPLICATION FOR GROUP VISION CARE

This application should only be completed by groups requesting vision coverage through the MedBen VisionPlus program; it should not be used if enrolling in other MedBen Mutual coverages. To enroll in MedBen VisionPlus and other MedBen Mutual products, please use *Employer Application and Request for Participation in Trust (MBM-EMPAPP-001)*.

Part I: Employer Information

Group Name ______________________________

Address ______________________________

City ____________________ State ____________ Zip Code ________

Requested effective date of group coverage: __________ Phone: ( ) __________ Fax: ( ) __________

Key Contact ______________________________
Name Title Phone

Daily Contact ______________________________
Name Title Phone

Type of Business ______________________________ SIC Code ________

Part II: Employee Information

Current Employees are eligible upon the effective date of this coverage. Newly hired employees will be covered as they become eligible for benefits. Dependents, if eligible, are the covered employee's spouse and unmarried dependent children who have not attained age 19, or age ❒ 23 ❒ 25 , if attending school full time. Unless retiree coverage is provided, it is understood that no employee shall become covered while not actively at work on a full-time basis, and only full-time employees working at least thirty (30) hours per week shall become eligible.

A. Future employees will be effective on: ❒ the first date following _____ days/months of full-time continuous employment
❒ the first of month following _____ days/months of full-time continuous employment

If enrollment changes are subject to an open enrollment period, please specify: ______________________

B. Are retirees eligible for coverage in this program? ❒ Yes ❒ No

If "Yes", please indicate the total number of retirees to be covered: ________

C. Will dependents of employees be covered under this program? ❒ Yes ❒ No

D. Will employees contribute toward the cost of the coverage? ❒ Yes ❒ No If "Yes", for whom? ❒ Employee & Dependents ❒ Dependents only
If "Yes", indicate the percent of employer's contribution: _________%

E. Total employees: _______ Total eligible employees __________ Total employees enrolling for coverage: ______

Are any of the enrollees COBRA participants? ❒ Yes ❒ No If "Yes", please submit a copy of each participant's COBRA election form.

F. How will VisionPlus receive enrollment information: ❒ Manual ❒ Tape ❒ Electronic Transfer

If by tape or electronic transfer, which update method will be used: ❒ Complete Replacement ❒ Adds/Deletes

G. Will past service history information be supplied? ❒ Yes ❒ No

Part III: Plan Information - *All benefits are based upon plan year.*

A. Plan Type (exam/lens/frame): ❒ (24/24/24) ❒ (12/24/24) ❒ (12/12/24) ❒ (12/12/12) ❒ Other

B. Panel Deductible $__________/$__________ Apply to Non-Panel benefits? ❒ Yes ❒ No

C. Plan Allowances: Frame $ _________ Contact Lenses $ ______

Covered Extras: ______________________________

D. Non-Panel benefits will be paid in accordance with the following schedule unless otherwise indicated:

Examinations: *$35* *Single Vision Lenses:* *$25* *Bifocal Lenses:* *$40*
Frames, up to: *$30* *Trifocal Lenses:* *$50* *Lenticular Lenses:* *$80*
Elective Contact Lenses: *$80* *Necessary Contact Lenses:* *$160*

Part IV: Financial Information

First Month's Premium Payment	*Number of Employees*	*x*	*Rate*	*Total*
Employee Only	____________	*x*	$_______	$____________
Employee + 1 Dependent	____________	*x*	$_______	$____________
Employee + Family/Composite	____________	*x*	$_______	$____________
Total Amount Due:				$____________

Part V: Agent Information

Commission Paid To ______________________ Agent Number ______________ _______ %

Commission Paid To ______________________ Agent Number ______________ _______ %

Contact Name ______________________ Telephone Number ______________

Address: ____

License Number, SSN or Tax ID Number: ____________ GA: ____________ GA Number: ____________

Are you currently licensed with MedBen? ❒ Yes ❒ No

Part VI: Contractual Information

The undersigned employer, engaged primarily in the industry described on Part I, hereby requests that it be approved as a participant in the Trust established by other participating employers for the purpose of purchasing group insurance for the benefit of its employees and requests inclusion as a participant under the Group Insurance Plan(s) issued to the Trustee for the plans(s) of insurance shown in Part 3 or in any required Supplement.

It is understood that no individual shall become insured while not actively at work on a full-time basis, and only full-time employees shall become eligible. Full-time employment is defined in Part II of this application. It is further understood that no agent has power on behalf of Medical Benefits Mutual Life Insurance Co. to make or modify any request or application for insurance or to bind said insurance company by making any promise or representation or by giving or receiving any information.

The employer declares that he/she has read the statements and the answers to the questions and that they are complete and true. The employer understands and agrees that this application is offered to Medical Benefits Mutual Life Insurance Co. as an inducement for the issuance of the insurance applied for, such insurance to be in the amounts agreed upon between said insurance company and the employer. The employer understands that withholding information or providing false statements is grounds for rescission of the group's coverage back to the original effective date.

Medical Benefits Mutual may make additions, corrections or deletions to this Employer Application as is deemed necessary in order to expedite processing. All such additions, corrections or deletions shall be identified to you in writing through an addendum to this application. You will retain the right to challenge any changes made and if any disputes are not resolved, you may choose to withdraw your application. You will also receive a copy of this modified application. Acceptance of the changes is verified by execution of the addendum.

It is further understood that no insurance will be effective until the plan is accepted in writing by Medical Benefits Mutual Life Insurance Co. No contract of insurance is to be implied in any way on the basis of the completion and submission of the specifications shown on this form. In case this application is not accepted, any binding premium advanced by the employer shall be refunded.

Dated At (Location)**:** ______________________ **Date:** ______________

Employer's Legal Name: ____________________________________

Employer's Signature: ______________________ **Title:** ______________

Witnessed By: ____________________________________

Administered by
VisionPlus of America, Inc.
1975 Tamarack Road
Newark, Ohio 43055
(800) 252-3447

WARNING: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.