

New Group Quotation Form

GROUP PROFILE - Please Print or type

Legal Name of Employer: _____

Requested Effective Date of Coverage: _____

Address: _____

Street Address

P.O. Box (If Applicable)

City

State

ZIP

County

Phone Number: (____) _____ - _____ Nature of Business: _____ SIC: _____

Business Type: Association Sole Proprietorship Partnership Corporation Other

Subsidiaries Included: Yes No (Please attach names and addresses on a separate page.)

Employer Contact: _____ Title: _____

Contact Phone Number: (____) _____ - _____ Contact FAX Number: (____) _____ - _____

ELIGIBILITY

Description of Persons Eligible _____

Vision Coverage

Is Vision Coverage currently provided? Yes No

If yes, please provide:

a) Copy of SPD or solicitation materials needed to enroll, including rates.

b) Premium and claim history for minimum of three (3) years (5 years if available.)

c) Census data by zip code for all eligible employees

d) Eligible employees _____ Number enrolled _____

e) Contract type: Fully-Insured

Self-Insured

Other

f) Funding type: Non-contributory (Employer Paid)

Voluntary (Employee Paid)

Contributory

Amount employer pays: _____% or \$ _____

Amount employee pays: _____% or \$ _____

g) Are benefits subject to union negotiation? Yes No:

If yes, please attach a copy of the current union contract.

If no, please indicate the type of coverage required

Type of Funding:

True Group (Employer Paid)

Non-Contributory (100% Employer Paid)

Voluntary Group (Employee Paid)

Contributory (_____ % Participation Required)

20% Voluntary, 75% True Group, 100% non-contributory

Amount employer pays: _____ % or \$ _____

Amount employee pays: _____ % or \$ _____

(continued on back)

Eligibility Waiting Period:

New Employees: First day of month coinciding with or following _____ days of employment.
 Other _____

Present Employees: All are eligible immediately, regardless of length of service.
 Only those who have satisfied the waiting period are eligible. (Please provide hire dates.)

Eligibility Hours Worked Per Week:

30 or more Other _____

Dependent Coverage Age Limit: to age 19
 Students to age 23 24 25 29

Type of Coverage:

Vision Management Services (VMS)

Frequency: Exam/Lenses/Frames/Contacts:

(12/12/24/12) (12/12/12/12) (12/12/24/24) (24/24/24/24) Exam Only (12)

Materials Only Other: _____

Retail Plan Allowances: Frame: \$72 \$82 \$92 \$102

Contact Material: \$60 \$75 \$100

Covered Extras: _____

*Copay(s): \$_____/Exam \$_____/Materials

Non-Participating Schedule: Standard Other (Attached)

ExamPlus

\$0 Co-pay (Exam) \$10 Co-pay (Exam)

EMPLOYER / AGENT INFORMATION

Please indicate the name, position, and telephone number of an employee in your firm who can provide necessary clarification of application information:

Name: _____ Position: _____ Telephone: _____

AGENT INFORMATION

Printed Name _____ Date _____ Signature _____

Business Address _____ City _____ State _____ Zip Code _____

Telephone _____ Agent No. _____ Agency _____