Supplemental Questionnaire for Group Vision Preferred Provider Organization (PPO) Policy

Employer Contribution:

☐ None - Coverage is voluntary ☐ Employer Contribution *(Indicate amount below)*

☐ Fully Insured ☐ ASO

Employer Contribution for Employee: $_____ or _____ % per month

Employer Contribution for Dependents: $_____ or _____ % per month

Eligibility Period:

☐ Coverage is effective on the date of hire.

☐ Coverage begins _____ days from the date of hire.

☐ Coverage begins the first day of the month following the date of hire.

☐ Coverage begins the first day of the month following _____ days of employment.

Remarks/Additional Information:

Broker Information:

Producer Name:			Agency Name:
Address:			City:
State:	Zip:	Phone:	Email:

Account Manager Name:			Agency Name:
Address:			City:
State:	Zip:	Phone:	Email:

Broker Commission Payable to:

☐ Broker ☐ Agency

Tax ID # for Commissions:

General Agency Information (If Applicable):			
Producer Name: Lisa McKinney			Agency Name: MANUFACTURER & BUSINESS ASSOCIATION INSURANCE AGENCY
Address: 2171 West 38th Street			City: Erie
State: PA	Zip: 16508	Phone: See File	Email: See File

Account Manager Name:			Agency Name:
Address:			City:
State:	Zip:	Phone:	Email:

General Agency Commission Payable to:	
☐ Broker	☒ Agency MANUFACTURER & BUSINESS ASSOCIATION INSURANCE AGENCY
Tax ID # for Commissions: See File	