Application for Group Vision Pennsylvania Preferred Provider Organization (PPO) Policy

Proposed Effective Date of Group Policy		
Effective Date:	☐ New Application	☐ Change

Employer Information – Group Policyholder		
Legal Name of Group Policyholder:		
Phone Number:	E-mail:	Type of Business:
SIC Code:	Employer Tax Identification Number:	
Type of Ownership: ☐ Sole-Proprietorship ☐ Partnership ☐ Corporation ☐ Other *(Please specify (e.g., LLC, LLP, Government Agency, etc.):*_____		

Mailing Address: **(Address where group wants to receive bills)**			
Address:			
City:		State:	Zip Code:
County:	Phone:	Email:	

Billing Contact Address: **(If different than Mailing Address above)**			
Billing Contact:			
Address:			
City:		State:	Zip Code:
County:	Phone:	Email:	

Group Administrator Contact Address: **(If different than Mailing Address above)**			
Group Administrator Contact:		Title:	
Address:			
City:		State:	Zip Code:
County:	Phone:	Email:	

Eligibility Contact Address: (If different than Mailing Address above)			
Eligibility Contact:			
Address:			
City:		State:	Zip Code:
County:	Phone:	Email:	

Representations – Agreement

I agree: (1) that the statements and answers given in this application are true, complete and correctly recorded to the best of my knowledgeand belief; (2) that this application will be part of the group policy for which I apply; (3) I will notify Vision Benefits of America, Inc. ("the Company") if any statements or answers given in this application change prior to policy delivery.

I understand that the group policy may be renewed each year on the policy anniversary date at the option of the Company, unless I notify the Company to terminate the group policy. Such notification will be provided to the Company at least [45] days prior to the termination date.I understand that termination of group policy is subject to the terms and conditions provided in the group policy.

I understand and agree that fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this application before action can be taken on this application.

I understand and agree that: (1) coverage is not in effect unless and until I receive notification of acceptance from the Company; (2) if this application is declined, the Company will return all premium deposits submitted with this application, if any; (3) if applicable, the initial premium for the group policy must be paid in advance of the due date; (4) the Company will issue the group policy to me; and (5) the Company will provide me with employee certificate forms and outline of coverage forms, if applicable, that I must distribute to covered employees.

I understand that: (1) the Company will rely on the information I provide in this application: (a) in determining eligibility for the group policy coverage for which I apply; (b) in setting premium rates; and (c) for other enrollment purposes; and (2) any misrepresentation or fraudulent statement in the application may result in: (a) rescission of the group policy; (b) termination of coverage; or (c) denial of claims; or (d) other consequences as permitted by law.

I agree that the Company will be entitled to rely on the most current information in its possession regarding eligibility of employees and their dependents in providing coverage under the group policy. I understand and agree that I am responsible for notifying the Company promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of newly eligible employees or dependents.

No licensed insurance agent is authorized to: (a) make or modify contracts; (b) waive any insurer rights or requirements; and (c) waive any information that the insurer requests.

READ YOUR POLICY CAREFULLY.

FRAUD WARNING:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature of Employer Applicant (Group Policyholder)	Title	Date / /
Printed Name of Licensed Insurance Agent	Signature of Licensed Insurance Agent	Date / /
Agent License Number	State of Agent License	