# 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: | | | Agency Name: |
| Address: | | | City: |
| State: | Zip: | Phone: | Email: |

| | | | |
|---|---|---|---|
| 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 | |