VBA GROUP # _____

VISION BENEFITS OF AMERICA

APPLICATION FOR GROUP VISION CARE COVERAGE

All Applicable Questions Must Be Completed

MANUFACTURER & BUSINESS ASSOCIATION - GOLD PLAN SIC CODE:

GROUP INFORMATION

TAX ID#

1 Full Legal name of proposed group: _____

(As it is to appear on Contract)

Address: _____

City: _____ State: _____ Zip: _____

County: _____ Phone: _____ Fax: _____

2 Plan Administrator

Name: _____ E-mail: _____

Address: _____

(If different from above)

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

3 Contact for Billing Information _____ Phone: _____

(If different from above)

E-mail: _____

4 Billing Address _____

(If different from above)

5 Nature of Business _____

6 Dependents: If eligible, dependents are the covered employee's/member's spouse and children (No age limit for mentally retarded/physically handicapped children who remain dependent on the employee).

7 Requested Effective Date (Effective date should not precede date of receipt of this application by VBA).

This plan will become effective on the 1st day of _____ 20 _____ provided that all of the following has been completed prior to this effective date.

A. Application has been received and accepted by VBA.

B. VBA has been furnished a list of all employees showing name, social security number, and single/family status, if applicable.

X Insured Program: _____ Self-Funded Program: _____ % of Gross Claims Cost

	No. of Employees	Rate	Total Remittance
# Employee Only		5.35	
# Two Party		10.14	
# Employee + Spouse			
# Employee + Child(ren)			
# Employee + Family		13.83	
# Composite Unit			

PLAN DETAILS

	EMPLOYEE	SPOUSE	CHILDREN
VISION EXAM	12 Months	12 Months	12 Months
LENSES	12 Months	12 Months	12 Months
FRAME	12 Months	12 Months	12 Months
OR			
CONTACT LENS SERVICES (includes fitting & lenses)	12 Months	12 Months	12 Months

VBA PARTICIPATING DOCTOR COVERAGE

Full Coverage - Paid In Full

Routine Exam
Lenses (Glass or Plastic)
Single Vision
Bifocals
Trifocal
Lenticular
1 Yr. Scratch
Blended No-Line Bifocals
Polycarbonate Lenses for Children up to age 19
Slab Off
Prism Segments
Double Segments

Partial Coverage

Patient Pays Some Added Cost

Progressive
Glass Photochromic
Polished Edges
Anti-Reflective Coatings
Mirror Coatings
Polycarbonate Lenses (Adult)
2 Yr. Scratch
Tints
Frames which cost more than Plan's Allowance
Rimless Frames
UV Coatings

Wholesale Frame Allowance

VBA Participating Provider $ 50.00

OR

Contact Lens Allowance

Medically Necessary - Covered

Elective - $ 150.00 (Selected in lieu of glasses in addition to the exam allowance)

Fitting = 15% off Provider's UCR

Copayment: N/A

NON-PARTICIPATING PROVIDER REIMBURSEMENT SCHEDULE

Vision Exam $ 40.00 Lenses Single Vision $ 40.00 Trifocal $ 80.00

Frame $ 50.00 Bifocal $ 60.00 Lenticular $ 120.00

OR

Contacts (Selected in lieu of glasses):

Medically Required $ 450.00 Elective $ 150.00 LVA $ 650.00

Lasik Surgery: Maximum Reimbursement of $200.00. Once every 8 years.

AGREEMENT

The undersigned group hereby applies for vision coverage through Vision Benefits of America.

It is understood that:

A. The group will cover **all eligible employees.**

B. All future employees will be covered when they become eligible.

C. The group is a current member of the Manufacturer & Business Association.

This application signed this _____ day of _____ 20 _____

◆ **By** _____ Title _____

(Signature)

By _____ Title _____

(Print or Type)

BROKER / CONSULTANT

Firm Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ E-Mail _____

Contact Name _____

Commission Checks payable to: Firm Name _____ Contact Name _____ Other _____

Taxpayer ID# _____ VBA Broker # _____

This application signed this _____ day of _____ 20 _____

◆ **By** _____ Title _____

(Signature)

By _____ Title _____

(Print or Type)

A COPY OF THE CONTRACT WILL BE PREPARED AND FORWARDED AFTER VBA'S RECEIPT OF THIS SIGNED APPLICATION.

400 Lydia Street, Suite 300, Carnegie, PA 15106 1-800-432-4955 Fax: 412-881-7319 www.vbaplans.com