VBA GROUP # ____________

VISION BENEFITS OF AMERICA

APPLICATION FOR GROUP VISION CARE COVERAGE

All Applicable Questions Must Be Completed

MANUFACTURER & BUSINESS ASSOCIATION - SAFETY 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 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.

____ Insured Program: X Self-Funded Program:
10 % of Gross Claims Cost

	No. of Employees	Rate	Total Remittance
# Employee Only			
# Two Party		N/A	
# Employee + Spouse		N/A	
# Employee + Child(ren)		N/A	
# Employee + Family		N/A	
# Composite Unit		N/A	

PLAN DETAILS

EMPLOYEE

VISION EXAM	12	Months
SAFETY LENSES	12	Months
SAFETY FRAME	24	Months

VBA PARTICIPATING DOCTOR COVERAGE

Full Coverage - Paid In Full			Partial Coverage Patient Pays Some Added Cost	
Routine Exam		Slab Off		
Safety Lenses (Glass or Plastic)		Prism Segments	Progressive	2 Yr. Scratch
Single Vision		Double Segments	Glass Photochromic	Tints
Bifocals	Blended No-Line Bifocals		Polished Edges	Frames which cost more than Plan's Allowance
Trifocal			Anti-Reflective Coatings	
Lenticular	Polycarbonate		Mirror Coatings	Rimless Frames
1 Yr. Scratch				UV Coatings

Wholesale Safety Frame Allowance

VBA Participating Provider $ 40.00

Copayment: N/A

NON-PARTICIPATING PROVIDER REIMBURSEMENT SCHEDULE

Vision Exam	$ 40.00	Lenses	Single Vision	$ 40.00	Trifocal	$ 80.00
Frame	$ 40.00		Bifocal	$ 40.00	Lenticular	$ 120.00

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.

◆ **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.