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

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:

General Agency Information (If Applicable):

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

Commission Payable to:

☐ Broker ☐ Agency

Tax ID # for Commissions: