APPLICATION FOR VISION CARE PLAN (WA GA CMI)

Provided by VSP Vision Care, Inc.
One Union Square Building
600 University Street, Suite 2004
Seattle, WA 98101-1123

ADMINISTRATIVE OFFICES:
3333 Quality Drive, Rancho Cordova, CA 95670
(800) 852-7600

CLIENT INFORMATION

1	Full legal name of client as it appears on the policy:			
	Address:			
	City:	County:	State:	ZIP:
	Phone:	Fax:	E-mail:	
	Principal Contact:		Title:	
	Client is headquartered in state of (if different from above)			
2	Who should we contact with payment questions?		Title:	
	Phone:	Fax:	E-mail:	
3a	Who should we contact with eligibility questions?		Title:	
	Phone:	Fax:	E-mail:	
3b	Does your broker need access to view/manage/update your eligibility? yes☐ no☐			
4	Who is the Benefit Administrator responsible for the overall administration of the plan (if not the Principal Contact)?			
	Name:		Title:	
	Phone:	Fax:	E-mail:	
	If multiple benefits administrators are at other locations, attach separate list, with names, addresses, email, phone, and fax numbers.			
5	What is the nature/type of your business?			
6	Membership information will be sent to VSP via: ☐Electronic Transfers ☐Online Eligibility Management			
	If electronic transfer reporting OR if a third party will handle your eligibility, please provide Third Party Administrator Information. Firm:			
	Contact:	Title:		
	Address:			
	City:	County:	State:	ZIP:
	Phone:	Fax:	E-mail:	
	In conjunction with health plan industry practices when providing electronic eligibility, VSP requests clients to send dependent eligibility information to VSP. This would include providing the covered dependent's full name, date of birth, and relationship to the employee/member. Dependents will be reported as a dependent under the employee's ID number. Will dependent information be sent to VSP for eligibility purposes? ☐yes ☐no If no, please explain: *Employers without Internet access for making membership updates will be contacted by VSP to review other options.*			
7a	Is a COBRA division is required? ☐yes ☐no			
7b	Names of additional divisions that require separate billing.			
	Address of additional divisions if applicable. **IMPORTANT:** Separate divisions will be billed on separate invoices (*If multiple divisions are needed, attach list of division names, contact names, address, email, phone, and fax numbers*):			
	Billing address (if different than Client address):			
	City:	County:	State:	ZIP:
	Phone:	Fax:	E-mail:	

If Self-Funded Program, do claims billings and administrative fee billings go to the same person? ☐yes ☐no

If no, please supply contact, title, address, phone, and fax number for each type of billing.

8 Send employee benefit information* to (select one):

Client's Benefit Administrator☐ Third Party Administrator☐ Broker/Consultant☐ Other☐-please specify:

** Any non-VSP-created information outlining coverage or plan details must be reviewed by VSP prior to distribution to members.*

9 Number of employees eligible for benefits:

Does this represent the total number of employees in the company? yes☐ no☐ total number:

Do you have employees in Canada? yes☐ no☐

Do you provide benefits to your retiree population? yes☐ no☐

10 Dependents: Eligible dependents are the covered employee's spouse and dependent children until the end of the month that they reach their [ ] birthday, or the end of the month that they reach their [ ] birthday, if attending school full time. (Includes an unmarried child if incapable of self-support because of physical or mental incapacity that commenced prior to reaching the above age)

Dependents other than employee's spouse & children:

☐ domestic partners (all) ☐ domestic partner's children

☐ domestic partners (same sex only) ☐ parents (IRS qualified)

11 Third party administrator (if applicable):

Firm:

Address:

City:	County:	State:	ZIP:
Contact:		Title:	
Phone:	Fax:	E-mail:	

12 As a health care service contractor licensed to do business in the State of Washington, VSP is required by state law to file with the Washington Office of Insurance Commissioner (OIC) a copy of each negotiated group contract to ensure compliance with applicable law. For each contract negotiated with an association or trust, the following information must be submitted to the OIC by VSP:

Is client an association or trust? yes☐ no☐ If no, skip this question number. If yes, complete the following:

a. Purpose of the association or trust:

b. If the association or trust is not the purchaser and policyholder, please state who is:

c. Attach or list eligibility rules for membership in the association or trust including membership fees if any:

d. Attach or list eligibility rules for purchasing coverage through the association or trust:

POLICY DETAILS

The rates listed must support the plan design and benefit selected and must meet all eligibility requirements. Please refer to your VSP-provided rate sheet for details or contact your VSP Account Executive. Any discrepancies may preclude acceptance by VSP.

13 Benefit Year (select one):

Service Year (from last date of service) ☐

Calendar Year (**IMPORTANT:** only available if policy effective date and renewal date is January 1st) ☐

14 Plan Type (select one):

VSP Signature Plan ☐ Exam Plus ☐ Exam Plus w/Allowances ☐

VSP Choice Plan ☐

15 Is vision benefit: Core ☐ Voluntary ☐ Packaged with medical and/or dental ☐

If **Voluntary** (vision is included as a stand-alone menu item in a list of benefits to choose from.):

Employer contribution percentage: for employee: % for dependent: %

If **Core Plus Options** (group provides a basic level of vision coverage to all employees with an option for the employee to buy up or enhance the benefit):

Employer contribution percentage: for employee: % for dependent: %

If **Packaged** (vision is tied to which of the following benefits: medical ☐ dental ☐

Employer contribution percentage: for employee: % for dependent: %

Voluntary Participation Structure:

**A minimum number of enrolled employees may apply.*

Exam w/Voluntary Materials* ☐ Voluntary Pool 0-24% employer contribution* ☐

Voluntary Pool 25% or more employer contribution* ☐ Core Employee/Voluntary Dependent Coverage* ☐

16 Frequency of Service (select one):

A (12/24/24 (**IMPORTANT:** 12/24/24 is not available on voluntary plans)) ☐

B (12/12/24) ☐

C (12/12/12) ☐

Other ☐:

Total co-payment: $ (applies to exam and eyewear)

OR

Split co-payment: $ Exam / $ Eyewear

17a Elective Contact Lens (Allowance): ☐ $120 ☐ $130 ☐ $140 ☐ $150 ☐ $180 ☐ other: $

Frame (Retail Frame Allowance): ☐ $120 ☐ $130 ☐ $140 ☐ $150 ☐ $180 ☐ other: $

17b Client has purchased Enhancements: ☐yes ☐no

☐Scratch Coating ☐Anti-Reflective Coating ☐Progressive Lenses ☐Photochromic / Tint

17c Client has purchased Enhancements or Specialty Care: yes ☐ no ☐

☐ Covered Contact Lenses
☐ Second Pair of Glasses
☐ Vision Therapy
☐ Primary Eyecare
☐ ProTec Safety
☐ Computer Vision Care
☐ Laser VisionCare Preferred Plan (available on a self-funded basis only to clients with 200+ enrolled employees)

18 Requested effective date *(The effective date should not precede date of receipt of this application by VSP.)*

This policy will become effective on the first day of [ ] (month) [ ] (year), provided that all of the following has been completed prior to this effective date:

A. VSP has received and accepted this application.

B. VSP has received and accepted Membership, including the required information of all employees that will be covered under this policy showing name, member ID, and dependents, if applicable.

20 Schedule A Information: Fiscal Year [ ] through [ ].

Schedule A will be sent to the person named as the principal contact. A copy of the report may also be sent to your broker and/or your third party administrator.

21 Do you currently have vision coverage: ☐yes ☐no If yes, current vision plan carrier:

If current carrier is VSP, please provide client name:

22 Names of affiliates or subsidiaries with VSP coverage under a separate contract:

23 For fully-insured programs *(VSP will bill for the first month's premium)*

Rates
$
$
$
$

IMPORTANT: Sold rates are required to process this application

24 For self-insured programs, Administrative Fee:

Administrative fee: or Percentage of claims: %

AGREEMENT

The undersigned client hereby applies for vision care coverage through VSP. It is understood that:

A. All future employees will be covered when they become eligible, or offered VSP coverage if voluntary.
B. Coverage will terminate for an employee on the last day of the month in which employment terminates.
C. Member past service for clients previously covered by VSP will carry over and remain in force.
D. Any non-VSP-created information outlining coverage or plan details must be reviewed by VSP prior to distribution to members.
E. This agreement will continue in force 24 months from the effective date. Rates are based on the assumption that VSP will receive these amounts over the full plan term.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

This application signed this [ ] (day) of [ ] (month) of [ ] (year).

Firm/Organization:

Name: Title:

Signature:

GENERAL AGENT

Please send a copy of agent/broker license, if not currently on file with VSP.

Legal Firm Name: Connexion Insurance Solutions

Address: PO Box 34315

City: Seattle County: State: WA ZIP: 98124

Licensed Producer's Name: Stacey Dixon Title:

Phone: 800-228-5798 Fax: E-mail:

Broker Assistant Name: Phone: E-mail:

Taxpayer ID: 91-0947106 Corporation☐ Independent☐

Commission Checks Payable to:
☒Firm Name
☐Contact Name
☐Not Paid

Name: Connexion Insurance Solutions

Address: see above

City: County: State: ZIP:

This application signed this [ ] (day) of [ ] (month) of [ ] (year).

Print Name: Stacey Dixon Title: Vice President

Signature of state-licensed agent: 

Please send a copy of agent/broker license, if not currently on file with VSP.

BROKER / CONSULTANT

☐ The broker/consultant indicated below is hereby designated Broker of Record by the above signed employer.

Broker of Record Legal Firm Name:

Address:

City: County: State: ZIP:

Licensed Producer's Name: Title:

Phone: Fax: E-mail:

Additional contact name: Phone: E-mail:

This application signed this [ ] (day) of [ ] (month) of [ ] (year).

Signature of state-licensed agent: License #:

Please include a copy of agent/broker license, if not currently on file with VSP.

COMMISSION CHECKS PAYABLE TO

Commission Checks Payable to: Connexion Insurance Solutions

☒ Firm Name
☐ Contact Name
☐ Not Paid

Taxpayer ID: 92-0947106

☐ Corporation
☐ Independent

☐ Same as licensed producer listed above

☐ Other: Legal Firm Name:

Address: PO Box 24315

City: Seattle County: WA State: WA ZIP: 98124

Phone: Fax: E-mail: commissions@connexioninsurance.com

ACCOUNT MANAGEMENT / SERVICE / RENEWALS

BROKER/CONSULTANT LISTED BELOW TO RECEIVE CORRESPONDENCE

☐ Same as licensed producer listed above

☒ Other: Legal Firm Name: Connexion Insurance Solutions

State-licensed Agent / Contact Name: Stacey Dixon License #:

Address: PO Box 34315

City: Seattle County: State: WA ZIP: 98124

Phone: 800-228-5798 Fax: E-mail: producer.support@connexioninsurance.com

If additional broker/consultant is to have access to this account, copy page and specify commission percentage split (if applicable).

Include copy of agent/broker license if not currently on file with VSP.