



VISION EMPLOYER PARTICIPATION APPLICATION FOR THE JOINT EMPLOYER GROUP INSURANCE TRUST



Companion Life Insurance Company • PO Box 100102 • Columbia, South Carolina 29202-3102

800-753-0404 FAX 803-735-0736

Please Print or Type

EMPLOYER INFORMATION

1. Full legal name of applicant (as it should appear in policy) Telephone Number ()
2. Applicant's Federal Tax ID Number
3. Address Street Post Office Box
City County State ZIP
4. Administrative Correspondence with the Applicant should be addressed to: Name Title Fax Number Email Address
5. Nature of Business 6. Requested Effective Date:
7. Are there subsidiary businesses covered under this plan? If YES, please state name and nature of each subsidiary or affiliate.
Are separate billings required? If YES, please provide billing instructions.
8. Type of Administration: Home Office Administered Self Administered

EMPLOYEE ELIGIBILITY

9. The normal work week for full-time employees is ___ hours. The normal work week for full-time employees must be at least 30 hours. Employees working less than 30 hours per week may be acceptable. Contact Companion Life for approval.
10. Current eligible employees are to be covered: Immediately on the requested effective date. After ___ days of continuous employment. First of the month following ___ days of continuous employment.
11. Employees hired after the plan effective dates are to be covered: Immediately. After ___ days of continuous employment. First of the month following ___ days of continuous employment.
12. Coverage following completion of the waiting period selected will be effective the first of the month following completion of the waiting period or the next billing date.

SPECIFICATIONS FOR INSURANCE

13. Will this coverage replace any existing vision insurance plan? If YES, name present insurance carrier: Yes No
14. Existing Plan Effective Date: 15. Termination Date of Existing Plan

Select your visionbydesign program on the reverse side.

16. Choose Benefit Design and Options (Required)		
<input type="checkbox"/> Vision Essentials Plan (Exam Only + Discount)	<input type="checkbox"/> Vision Choice Plan (Eyewear Only + Discount)	<input type="checkbox"/> Vision Select Plan (Exam + Eyewear + Discount)
Exam Copay: <input type="checkbox"/> \$0 <input type="checkbox"/> \$10 <input type="checkbox"/> \$20 Exam Frequency: 12 months	N/A	Exam/Lens Copays: <input type="checkbox"/> \$0/0 <input type="checkbox"/> \$10/\$10 <input type="checkbox"/> \$20/\$20 Exam Frequency: 12 months
N/A	Eyewear Allowances: <input type="checkbox"/> \$100 Frame/\$115 Contacts <input type="checkbox"/> \$130 Frame/\$130 Contacts Frames Frequency: <input type="checkbox"/> 12 months <input type="checkbox"/> 24 months Lens/Contact Lens Frequency: 12 months	Eyewear Allowances: <input type="checkbox"/> \$100 Frame/\$80 Contacts <input type="checkbox"/> \$130 Frame/\$120 Contacts Frames Frequency: <input type="checkbox"/> 12 months <input type="checkbox"/> 24 months Lens/Contact Frequency: 12 months
17. Choose Premium Rate Structure (Required) <input type="checkbox"/> Two Tier <input type="checkbox"/> Three Tier <input type="checkbox"/> Four Tier (If sold with Dental, Vision and Dental must have the same premium rate structure)		
18. Number of Eligible Employees: _____ 19. Number of Enrolled Employees: _____		
20. Percent of Premium Paid by Employer: <input type="checkbox"/> Single/Employee Only _____% <input type="checkbox"/> Family/Dependents _____%		
21. Special Vision Product Pricing: If employee contributions are involved, Companion Life offers special Vision Plan premium rates for employer groups offering a Companion Life Vision plan along with a Companion Life Group Dental Insurance plan. To qualify for these special Vision Plan rates, 100% of those enrolled in the Group Dental plan must also participate in the Vision plan.		
a. Will employees contribute to the cost of the Vision plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		
b. Will this Vision Plan be enrolled with a Companion Group Dental Insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		
c. If yes, will 100% of the employees and dependents enrolled in the Companion Life Group Dental plan be required to take the Vision Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		

FRAUD WARNING (Not applicable in AZ, FL, MD or VA): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal and civil penalties.

FRAUD WARNING (FL ONLY): Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Participation Agreement (Administered and underwritten by Companion Life Insurance Company)				
The Employer hereby applies for Group Insurance Benefits as set forth in the above "Vision by Design" Employer Participation Application for the Joint Employer Group Insurance Trust and subscribes to the Agreement and Declaration of Trust.				
Name of Trust: The Joint Employer Group Insurance Trust				
It is understood and agreed by the undersigned that the Trustee is not an insurer, nor does the Trustee have any obligation under any policy of insurance and that all claims for the benefits provided by insurance being applied for herein shall be made to and payable by the Insurance Companies issuing group policy(ies) to the Trustees, but only to the extent and in strict accordance with the provisions of such policy(ies). The Trust agreement and the group policy(ies) held by the Trustee are available for inspection during regular business hours by the Participant at the office of the Administrator, Companion Life Insurance Company, located at 7909 Parklane Road, Suite 200, Columbia, SC 29223-5666.				
_____ (Signature of Employer/Applicant)	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="padding: 5px;">HOME OFFICE USE ONLY Employer Group No.: _____</td> </tr> <tr> <td style="padding: 5px;">Accepted by Companion Life Effective: _____</td> </tr> <tr> <td style="padding: 5px;">By: _____ <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> (Title) (Date) </div> </td> </tr> </table>	HOME OFFICE USE ONLY Employer Group No.: _____	Accepted by Companion Life Effective: _____	By: _____ <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> (Title) (Date) </div>
HOME OFFICE USE ONLY Employer Group No.: _____				
Accepted by Companion Life Effective: _____				
By: _____ <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> (Title) (Date) </div>				
_____ (Title)	_____ (Date)			
_____ (Signature of Resident Agent/Broker)	_____ License No.			
_____ Print Agent's/Broker's Name	_____ License No.			

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-396-0188]。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đỡ với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건보함에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulongan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعد أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره ی این برنامه ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)
