

Avesis Discount ~ Option #1

MASTER APPLICATION FOR VISION DISCOUNT BENEFITS



I. EMPLOYER/ASSOCIATION INFORMATION

Group # _____

Employer/ Association Name: _____ Tax ID# _____

DBA Name (if other than above): _____

Business Address: _____ City _____ State _____ Zip _____

Mailing Address (if other than above): _____

Correspondent: _____ Title: _____

Email Address of Correspondent (if available): _____

Phone Number () _____ Fax Number () _____

If any subsidiary or affiliated companies are to be covered or any Employees are working at a location other than the address above, please explain:

Number of Full-time Employees/Members _____ Number of Participants: _____

Open Enrollment period: Annually

The renewal date will correspond with the open enrollment date(s)

II. PREMIUMS

Contribution towards premium Yes No Effective/Renewal Date: _____

Employer/ Association's Premium Contribution: _____ Premium received with application: _____

Annual Premiums available (check one) \$21.50 - 100% group participation \$25.50 Voluntary

To qualify for the \$21.50 premium a job service report or census of all eligible employees MAY be requested with this application to confirm 100% participation.

III. WRITING BROKER/AGENT INFORMATION

Broker/ Agent Name (print): _____

Address _____ City _____ State _____ Zip _____

Name/ Address Commissions to be made payable to (if different than above): _____

Broker Signature **X** _____ Phone # _____ Fax # _____

Please Note:

- Annual premiums shall be payable at the time of enrollment at the rates set forth in the proposal.
- Please attach a list of all participants to this application, consisting of name, social security # and home address. This list may be a hard copy, diskette or computer tape, or any other type of application (i.e. medical, life, etc.).
 - For groups over 100 in size we will need the enrollment to be set up in an Excel format. For those groups sent in on hard copy we will charge a one time annual administrative fee of \$1.00 per person.
- Master application **MUST** be filled out completely and sent in with enrollments and premium. This is to enable us to service you promptly. If enrollments are received without this application, or if it is incomplete, the enrollments will be mailed back to the agent.

Please send all applications/premium payable to:

Select Networks

317 6th Ave., Ste. 1040 • Des Moines, Iowa 50309-4112 • (515) 244-6282 • 1-800-797-6282

Fax (515) 237-8221

E-mail Address: jyoder@eyeplan.com

This is NOT insurance