Vision Service Plan (VSP)

Employer Application

Request Effective Date:		
Company Name:		
Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	
Contact Name:	E-mail Address of Contact:	

EMPLOYER INFORMATION

The undersigned applicant requests the Vision Plan Benefits shown herein and provided by Vision Service Plan (VSP).

Employer Paid ____ Employee Paid (Voluntary) ____

Total number of eligible persons: _____ Total number of covered persons: _____

Enrolled Census:	Employee	
	Employee + Spouse	
	Employee + Child(ren)	
	Family	

Service Frequency

Exam	12 Months
Lenses	12 Months
Frames	24 Months

Co-pays	$10 Exam
	$20 Eyewear

Benefits

	Network	Out-of-Network
Eye Examination	Covered in full	Up to $46
Spectacle Lenses		
Single Vision	Covered in full	Up to $45
Bifocal	Covered in full	Up to $65
Tri-focal	Covered in full	Up to $85
Lenticular	Covered in full	Up to $125
Frames	$120 Allowance	Up to $47

	· 20% discount on amounts exceeding allowance	
Elective Contact Lenses	$120 allowance toward contact lens exam (fitting and evaluation) and contacts	Up to $105
	· 15 % discount off contact lens service	
Medically Necessary Contact Lenses*	Covered in full	Up to $210

*Medically necessary contact lenses are covered in full from a VSP doctor if a medical condition, on a pre-approved list from VSP, prevents the member from wearing eyeglasses.

Rates

24 Month Rate Guarantee	Monthly Premium
Employee	**$**
Employee + 1	**$**
Family	**$**

Vision Benefits Cards -Important

There is no policy or certificate issued for this program. Each person enrolling should be given a generic Vision Benefits Card that describes how to receive benefits and file claims.

Please indicate where MorganWhite Administrators should send the Vision benefits Card (we will include additional cards for new hires).

___ Send Benefits Cards to the employer for distribution
___ Send Benefits Cards to the agent for distribution
___ Do not send Benefits Cards, the agent distributed them during the enrollment

The undersigned group hereby agrees to vision care coverage through Vision Service Plan (VSP).

It is understood that:

A. The group will make this plan available to all eligible employees and their dependents.

B. All future employees will have this plan available to them when they become eligible.

C. Coverage will terminate for an employee on the last day of the month of employee's termination.

Signature _____

Print Name _____

Title _____ Date_____

Signature of Agent or Broker _____

Print Name _____

Vision Enrollment Form

Group Vision Coverage Provided by
Vision Service Plan (VSP)

SOCIAL SECURITY NUMBER	EMPLOYEE ID NUMBER (if different than SSN)	☐ Enroll ☐ Cancel ☐ Change ☐ Waiver **EFFECTIVE DATE :** / /

LAST NAME	FIRST NAME	MI

ADDRESS	CITY	STATE	ZIP

TELEPHONE NUMBER HOME ( ) WORK ( )	☐ Male ☐ Single	☐ Female ☐ Married

APPLICANTS DATE OF BIRTH	EMPLOYER OR GROUP NAME

PLAN COVERAGE ☐ Employee ☐ Employee + One ☐ Family

INFORMATION FOR DEPENDENT COVERAGE

Spouse & Unmarried Dependent Children Only (Include Date of Birth)

First Name Initial Last Name (if different)	Date of Birth (Mo/Day/Yr)	Relationship			If Child is over 19, please indicate status and school	
		☐ Wife	☐ Husband	☐ M ☐ F	☐ Student at: ______ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel
		☐ Son	☐ Daughter	☐ M ☐ F	☐ Student at: ______ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel
		☐ Son	☐ Daughter	☐ M ☐ F	☐ Student at: ______ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel
		☐ Son	☐ Daughter	☐ M ☐ F	☐ Student at: ______ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel
		☐ Son	☐ Daughter	☐ M ☐ F	☐ Student at: ______ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel

*For court ordered dependent, legal documentation must be attached. Please see employer representative for more information about the qualifications for full-time student status. If dependent does not reside with eligible employee, please provide address on separate sheet.

FOR INTERNAL USE ONLY

EMPLOYER or GROUP AUTHORIZATION

EFFECTIVE DATE

TYPE OF COVERAGE

SIGNATURE ____________________

I hereby understand that any coverage is limited by the benefits and exclusions of the Group Dental Agreement