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by cbg

NEW GROUP SUBMISSION PROCESS

Submission Deadline: New group information must be postmarked no later than the 25th of the month to be effective for the first of the following month.

NEW BUSINESS CHECK LIST

Please confirm that the following is submitted with all new cases.

- ❑ Completed Employer Application (Applications must include company email address, as certificates will be furnished in electronic (.pdf) format.
- ❑ Completed Employee Enrollments
- ❑ First Month's Premium (Made payable to: Employer Plan Services, Inc.)
- ❑ Copy of Quote
- ❑ Producer Licensing Forms (if not previously contracted)

cbg
5006 Lyndale Avenue South
Minneapolis, MN 55419
(612) 827-0855 or toll free (888) 327-8880

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Vision Care Insurance Employer Application

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

EMPLOYER INFORMATION

The undersigned applicant requests the Vision Care Insurance Benefits shown herein and provided by United Healthcare Insurance Company, and agrees to be bound by the terms and provisions of the Vision Care Insurance Policy.

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	12Months
Frames	24 Months

Co-pays	$10 Exam
	$25 Materials

Benefits*

	Network	Out-of-Network
Eye Examination	100%	up to $40.00
Spectacle Lenses		
Single Vision	100%	up to $40.00
Bifocal	100%	up to $60.00
Trifocal	100%	up to $80.00
Lenticular	100%	up to $80.00
Frames	100%	up to $45.00
Elective Contact Lenses		
Covered-in-full contacts	100%	up to $150.00
All other elective contacts	up to $150.00	up to $150.00
Necessary Contact Lenses	100%	up to $210.00
Non-Selection Contact Lenses:	$150.00 allowance: every 12 months	

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Rates

	Monthly Premium*
Employee	$7.65
Employee + Spouse	$14.49
Employee + Child(ren)	$15.23
Family	$23.42

* Note: There is a $10 monthly administrative fee for CONFIDENT stand-alone vision.

Authorized Group Officer's Signature_____

Printed Name of Group Officer_____

Signature of Agent or Broker_____

Printed Name of Agent or Broker_____

Agency Name_____

Agent's Telephone No.:_____Agent's Fax No.:_____

Agent's License No.:_____

General Agency Name_____

Send completed application to

cbg
5006 Lyndale Avenue South
Minneapolis, MN 55419

FRAUD WARNING NOTICES: (Please review notice that applies in your state.)

For applicants in Arkansas and Louisiana:
Any person knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

For applicants in Colorado:
It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

For applicants in District of Columbia:
WARNING: It is a crime to provide false or misleading information to an insurer for purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the application.

For applicants in Florida:
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.

For applicants in Kentucky, New Mexico, Ohio and Pennsylvania:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For applicants in Maine, Tennessee and Virginia:
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

For applicants in New Jersey:
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For applicants in all other states:
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Voluntary Vision Enrollment Form

Group Voluntary Vision Coverage Provided
by UHIC in partnerhsip with Spectera Vision

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SOCIAL SECURITY NUMBER	EMPLOYEE ID NUMBER (if different than SSN)	DATE : / /

LAST NAME	FIRST NAME	MI

ADDRESS	CITY	STATE	ZIP

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

APPLICANTS DATE OF BIRTH	EMPLOYER OR GROUP NAME

PLAN COVERAGE ☐ Employee ☐ Employee + Spouse (or Domestic Partner) ☐ Employee + Child(ren) ☐ 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 ☐ Domestic Partner		☐ 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

SIGNATURE _____

I understand that any coverage is limited by the benefits and exclusions of the Group Voluntary Vision Agreement.

MINIMUM ENROLLMENT IS FOR ONE YEAR

CONFIDENT℠ by cbg in partnership with Spectera Vision Plans are underwritten by United HealthCare Insurance Company, Hartford, Connecticut (except in New York), United HealthCare Insurance Company of New York; Hauppauge, New York (New York Only).