



NMR Vision Care Plans Employer Enrollment

For NMR Use Only: Group No. _____	Requested Effective Date: _____
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Legal Name of Employer _____

Mailing Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____ Email Address _____

Nature of Business _____ Federal Tax I.D. No. _____ Contact Person at Firm _____

Employer Contribution	
The employer will contribute: _____% for employees _____% for dependents (All employees must enroll)	
Participation: Please choose one of the following participation options;	
<input type="checkbox"/> 100% of all FT employees are enrolled or <input type="checkbox"/> Matching medical enrollment (must submit copy of medical bill)	
Waiting Period for new Employees	
First of the month following continuous full-time employment of:	
<input type="checkbox"/> Standard 3 months <input type="checkbox"/> 2 months <input type="checkbox"/> 1 months Waiting Period Applies to Present employees? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employee Re-Hire: Are you waiving the employer probationary period for all employees that have been re-hired within 12 months of leaving the company? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employee Transfers: For employees transferring from part-time to full-time, the probationary period starts;	
<input type="checkbox"/> retroactive to original date of hire <input type="checkbox"/> the date the employee transfers to full-time	

Census Information

Total Number of full-time Employees	_____
Employees in Probationary period	_____
Total Number of part-time employees	_____
Total Number of employees	_____
Total number of Enrolled employees (all FT employees must enroll)	_____

Enrollment and Monthly Cost Calculation

	# of Employees	Rate	Total Premium
Employee Only	_____ X	_____ =	_____
Employee + 1	_____ X	_____ =	_____
Employee + 2	_____ X	_____ =	_____
Monthly Administration Fee			\$5.00
Total Estimated 1st Month's cost			
Initial premium check made out to:			
Northwest Marketing Resources, Inc. _____			

Benefit Plan Selected	Composite Plan B <input type="checkbox"/> (must have 20+ enrolled)		
Check Plan Chosen (check one)	Plan A <input type="checkbox"/>	Plan B <input type="checkbox"/>	Plan C <input type="checkbox"/>
BENEFITS:			
Deductible Per Year	\$20 exam/\$20 materials	\$10 Exam / \$25 materials	\$25 exam and materials
FREQUENCY OF BENEFITS:			
Vision Exam	Every 24 months	Every 12 months	Every 12 months
Lenses	Every 24 months	Every 12 months	Every 12 months
Approved Frames	Every 24 months	Every 24 months	Every 12 months

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BENEFITS FOR ALL 3 PLANS:		PANEL PROVIDER	NON PANEL PROVIDER
Vision Exam		100% Paid	Up to \$45
Lenses (per pair)	Single Vision	100% Paid	Up to \$45
	Bifocals	100% Paid	Up to \$65
	Trifocals	100% Paid	Up to \$85
Contacts	Elective (in lieu of spectacle lenses and a frame)	Up to \$130	Up to \$105
Frames	Approved Frames	\$130.00 Retail Value	Up to \$45.00

AGREEMENT/ ACKNOWLEDGMENT

The undersigned company hereby applies for vision care coverage with Northwest Marketing Resources (NMR) & Vision Service Plan. (VSP)

It is understood and agreed that:

1. An eligible employee is a full-time permanent employee of the employer who is: (1) permanently employed, working at least 20 hours per week and paid a salary, wages or earnings from which federal and state tax and social security deductions are made and (2) not covered by a collective bargaining agreement which requires the employer to make contributions. An eligible dependent is the employee's lawful spouse and the employee's or spouse's children (including adopted, foster and step-children) provided they are: (a) unmarried (b) under the age 26 (c) claimed as a dependent by the employee for federal income tax purposes.
2. All future new eligible employees will be enrolled immediately when they become eligible for coverage.
3. Employee coverage and dependent coverage will terminate end of the month that the employee/dependent is no longer eligible.
4. NMR is the designated administrative contractor of the plan for billing, premium collection, and eligibility reporting for the plan. There will be a monthly administration fee charged for the services.
5. All premiums for the plan are due and delinquent if not received by the administrative contractor by the 30th of each month.
6. The company agrees to provide the administrative contractor with any required information incident to the administration of the plan.
7. I certify that I understand and have enrolled all eligible employees and their dependents in accordance with the plan. I have discussed coverages, eligibility, and the expenses not covered with the Producer and understood them fully.
8. I certify that this is a bona fide business with a legitimate business purpose and which has a true employer-employee relationship with the individuals designated as employees. I understand that any false statements made in this application constitute the legal basis for termination or cancellation of the coverage retroactive to the effective date and denial of claims incurred.
9. The company agrees to be bound by these terms and the terms and conditions contained in the master contract issued by Vision Service Plan. It is also agreed and understood that this application will be made part of the master agreement.
10. Rates include 10% agent commission as well as administrative fees.

Date	Signature of Company Officer	Printed Name	Title
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Producer's Statement

Producer's Signature	Date
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Producer's Name	Phone No.	Email Address
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Agency Name	Tax Payer ID No.
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Agent/Agency Mailing Address

You must be appointed with Vision Service Plan in order to receive commissions for this program.

Send completed information to: Northwest Marketing Resources, Inc.
 1427 4th Ave E Olympia, WA 98506 or PO Box 447 Olympia, WA 98507
 (360) 352-8881 (800) 565-0313 Fax (360) 754-1931