VISION SERVICE PLAN

NMR VISION PLAN

For NMR Use Only

Group#_____

Employer Application

EMPLOYER NAME_____ **REQUESTED EFFECTIVE DATE**_____

Census Information	**Current**
A. Total Number of full-time employees	_____
B. Total number enrolled (All full-time must enroll)	_____
C. Total number of ineligible employees	*_____

*Reason _____

Complete this section if you have different classes of Employees

Class I _____
Class 2_____
Class 3_____

Enrollment and Monthly Cost Calculation

	Number of Employees	Rate	Total Premium
Employee only	_____	x $_____	= $ _____
Employee + 1	_____	x $_____	= $ _____
Employee + 2	_____	x $_____	= $ _____
Monthly Administration			+ $ 5.00
Total Estimated 1st Month's Cost			$ _____

Initial Premium check made out to:

Trusteed Plans Service Corp. or TPSC

BENEFIT PLAN SELECTED

Check Plan Chosen (check one)	**Plan A** _____	**Composite Plan B** _____ **Plan B** _____	**Plan C** _____
Deductible Per Service Year	$20 Exam $20 Materials	$10.00 - exam $25.00 - materials	$25.00 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 (covers tints)

BENEFITS FOR ALL 3 PLANS	**PANEL PROVIDER**	**NON-PANEL PROVIDER**
Vision Exam	100% Paid	Up to $42
Lenses (per pair)		
Single Vision	100% Paid	Up to $40
Bifocals	100% Paid	Up to $60
Trifocals	100% Paid	Up to $80
Lenticular	100% Paid	Up to $125
Contact		
Necessary	100% Paid	Up to $210
Elective (in lieu of spectacle lenses and a frame)	Up to $120	Up to $105
Approved Frames	$130.00 Maximum	Up to $45

EMPLOYER CONTRIBUTION/ELIGIBILITY --

The employer will contribute _____ % for employees and _____ % for dependents

WAITING PERIOD FOR NEW EMPLOYEES -- Choose One

First of the month following continuous full-time employment of:

If your eligiblity varies based on Class, indicate definitions below

_____Standard 3 months _____2 months_____1 month

(Class definitions_____)

Waiting period applies to present employees? ____Yes ____No

Application is hereby made for Company participation in the NMR Vision Plan, By:

LEGAL NAME OF EMPLOYER _____

STREET ADDRESS or P.O. BOX _____ CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____ EMAIL ADDRESS _____

NATURE OF BUSINESS _____ FEDERAL TAX I.D.# _____ CONTACT PERSON AT FIRM _____

AGREEMENT/ACKNOWLEDGMENT:

The undersigned company hereby applies for Vision Care coverage with the NMR/VSP Vision Care Plan.
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 age 19, extended to age 26 if a full-time student at an accredited college or university, or vocational, technical or trade school, and (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 on the earliest of the following dates: (1) the date the employee ceases to be an eligible employee or the date the dependent is no longer eligible as a dependent under the plan; (2) the date the plan is terminated; (3) the date the employer terminates the coverage by failing to pay the required premium; (4) the date the group policy is terminated. The benefits are subject to all the conditions and limitations of the plan.
4. Trusteed Plans 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 these services.
5. All premiums for the plan are due and delinquent if not received by the administrative contractor by the 16th 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 understand 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 coverage retroactive to the effective date and denial of all 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.

Date: _____ X _____

Signature of Company Officer Title

Producer's Statement

Producer's Signature _____ Date _____

Producer's Name _____ Social Security No. _____ Phone No. _____

Agency Name _____ Tax Payer ID # _____

Complete the next section only if this is your first case or information has changed

Address (Street or P.O. Box) _____

City, County, State, Zip _____

Indicate who should receive commission Producer _____ Company _____

Producer: Date of Birth Mo. _____ Day _____ Year _____

Insurance License No.* _____ State: _____

Please send the employer administration kit to: Employer _____ Producer _____
*If this is your first case, please include a copy of your State Life and Health License(s).

Send completed application to: Northwest Marketing Resources, Inc.
522 Franklin St SE ÅOlympia, WA 98501 or P.O. Box 447 ÅOlympia, WA 98507
(360) 352-8881 Å(800)565-0313 ÅFAX (360) 754-1931