New Business Checklist

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

- ❑ Completed application for group vision insurance
- ❑ Completed Broker Access Form
- ❑ Completed employee enrollment forms or census spreadsheet *(census is preferred for ease of processing)*
- ❑ Clients may wait until their first bill to send payment to Avesis*
- ❑ Sold Quote with elected plan and rates from www.directbenefits.com

Policy Documents Delivery Acknowledgement

Policy documents will be delivered via e-mail to the group administrator. Hard copy ID cards are available upon request or accessible through the portal after implementation.

After all the information listed above is completed and signed, submit all forms using one of the following delivery methods:

Email: agentsupport@directbenefits.com

Fax: **651-649-3502 ATTN: Group Sales**

Mail: **Direct Benefits, Inc.**
55 East 5th Street, Suite 500
Saint Paul, MN 55101

***Please note that initial premium checks must be sent to the following address:**

Avēsis Third Party Administrators, Inc.
PO Box 842531
Los Angeles, CA 90084-2531

Submission Date:
New groups should be received by Direct Benefits no later than the 10th of the month of the desired effective date in order to submit to the carrier (*i.e. Feb 1st effective date, please submit to Direct Benefits by Feb 10th)*.

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Application For Vision Care Benefits

Underwritten by Fidelity Security Life Insurance Company

Kansas City, Missouri

Policy No. VC-16

I. EMPLOYER INFORMATION

Employer Name: _____ Tax ID#: _____

DBA Name (if other than above): _____

Business Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Key Contact: _____ Title: _____

Phone Number: _____ Fax Number: _____ E-mail: _____

Executive Contact (if other than above): _____

Phone Number: _____ Fax Number: _____ E-mail: _____

Type of Business: ☐ Proprietorship ☐ Corporation ☐ Partnership ☐ Other (specify): _____

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

_____

_____

Will this plan replace any existing coverage: ☐ Yes ☐ No
(if yes, indicate name and address of existing insurer)

Name: _____

Business Address: _____ City: _____ State: _____ Zip: _____

(If "yes," are any employees on COBRA)? ☐ Yes ☐ No How many? _____

Effective date of existing coverage: _____

Termination date of existing coverage (if applicable): _____

Number of full-time employees: _____ Number applying: _____

Are domestic partners covered under this plan?* ☐ Yes ☐ No
*except as required by state law

Unless your specific state mandates otherwise, do you wish to cover dependents until age 26, regardless of financial dependency, residency, student status or marital status? ☐ Yes ☐ No

II. PLAN SELECTION

☐ Employer Paid ☐ Voluntary ☐ Contributory

Frequency (Exam, Lenses, Frames, Contact Lenses)

☐ 12 months, 12 months, 12 months, 12 months

☐ 12 months, 12 months, 24 months, 12 months

☐ 12 months, 24 months, 24 months, 24 months

☐ ___ months, ___ months, ___ months, ___ months

Exam Copay: _____

Materials Copay: _____

Frame Allowance: _____

Contact Lens Allowance: _____

Lens Option Package (if applicable): _____

LASIK Rider ($300 or $600): _____

Tier

☐ 2 Tier	Rate	☐ 3 Tier	Rate	☐ 4 Tier	Rate
Employee Only	_____	Employee Only	_____	Employee Only	_____
Employee + Family	_____	Employee + One	_____	Employee + Spouse	_____
		Employee + Family	_____	Employee + Children	_____
				Employee + Family	_____

III. PREMIUMS

Employee contribution towards premium?: ☐ Yes ☐ No

Employer's Premium Contribution for: Employees (%): _____ Dependents (%): _____

Are Employee and Dependent premiums being paid through a Section 125 Plan? ☐ Yes ☐ No

Are Employee and Dependent premiums being collected by payroll deduction? ☐ Yes ☐ No

Premium received with application: _____

Note: Please attach a list of all participants to this application. Premiums shall be payable in advance.

IV. ELIGIBILITY (Choose One)

PROBATIONARY PERIOD FOR NEW EMPLOYEES ☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 180 days

☐ Other: _____

Probationary Period is Waived for Present Employees: ☐ Yes ☐ No

ELIGIBLE CLASS (Choose One)

☐ The Employees eligible for insurance under the Policy shall be **all the full-time Employees** of the above-named Employer and each Employee's Dependents. If both husband and wife are Employees, either the husband or wife, but not both, may elect coverage for their Dependents. Eligible Dependents may be added to the Policy on any premium due date.

No Part-time Employee, or his or her Dependents, may be included as Eligible Persons.

☐ As used here, full-time Employee means an Employee who is performing all the usual duties of his or her position at the Employer's usual place of business at least 20-40 or more hours per week. A part-time Employee is an Employee who does not meet this definition.

Dependents may not be included as Eligible Persons unless the Dependent's parent or spouse is covered under the Policy.

☐ The Employees eligible for insurance under the Policy shall be **all the Employees** of the above named Employer, and each Employee's Dependents. If both husband and wife are Employees, either the husband or wife, but not both, may elect coverage for their Dependents. Eligible Dependents may be added to the Policy on any premium due date.

The Employees eligible for insurance under the Policy shall be _____

DATE ELIGIBLE

1. Each Employee included in an Eligible Class on the Policyholder's Effective Date will be eligible on that date, provided the Employee has completed any required probationary period shown below.
2. Each Employee included in an Eligible Class on the Policyholder's Effective Date, and who had partially satisfied the required probationary period prior to the Policyholder's Effective Date, will be eligible on the first day of the calendar month coinciding with or next following the date of completion of the probationary period.
3. Each Employee who enters an Eligible Class AFTER the Policyholder's Effective Date will be eligible on the first day of the calendar month coinciding with or next following:
    a. completion of any required probationary period; or
    b. the Employee's date of employment, if a probationary period is not required.

EMPLOYEE ENROLLMENT

1. Each Employee may request coverage for him or herself and eligible Dependents.
2. The Company reserves the right, based upon Our underwriting procedures, to require that the eligible Employee and/or eligible Dependent of a Policyholder submit an enrollment form and agree to pay any premium contribution, if required, before coverage will become effective for the Employee and/or Dependent.

DELAYED ENROLLMENT

Each Employee who waives or declines insurance when he or she becomes eligible will not be eligible again until the next Policy anniversary date or _____. If insurance is waived or declined for eligible Dependents then those Dependents will not become eligible again until the next Policy anniversary date or _____.

PARTICIPATION REQUIREMENT

The Policyholder is required to maintain the minimum participation requirements of the Company as follows:

If part of the premium is derived from funds contributed by the insured Employees, at least 10-25% of the eligible Employees must elect to make the required contribution, and at least 2-100 Employees must be covered on the Policy's Effective Date.

When a contribution is not required by the Employee, then 100% of the eligible Employees must be covered at all times.

V. EFFECTIVE DATE

It is desired that the policy shall become effective at 12:01 A.M. Standard Time at the Employer's address herein, on the day

of _____ , 20 _____ , provided this application shall have been accepted by the Company.

The Policy, if issued, rates are guaranteed for a term of _____ months/year(s).

The total premium rate is subject to modification based upon any change in benefits, policyholder contributions, number of eligible employees, information provided by the applicant on the application, governmental action or change in law or regulation, any of which, individually or in combination, may affect the Company's risk in underwriting this coverage. The rate guarantee is also subject to change for any regulatory assessments, fees, or taxes created by federal or state governments, and the associated administrative costs.

The Employer hereby makes application to Fidelity Security Life Insurance Company for Vision Care Benefits. The Employer agrees to maintain and furnish any records necessary to administer the plan, and to forward premiums monthly in advance.

The Employer certifies that all the information shown on this application and any attachments are correct and complete and understands that the Insurance Company intends to rely on this information in determining whether or not the enrolling Employees may become insured. It is further understood and agreed that **NO INSURANCE WILL BECOME EFFECTIVE UNTIL APPROVED BY THE INSURANCE COMPANY**; and that no field representative of the Insurance Company has the authority to modify any conditions of application, or policies, by making any promise or representation. It is understood that the insurance as to any Employee will not become effective on the date insurance should otherwise become effective if he is not at work on such date performing all duties of his occupation and otherwise meets the requirements of the Insurance Company.

By signing below, the Group agrees to receive all documents and correspondence electronically and that the Group can access the internet or the email address provided. The Group understands that the Group may revoke this authorization or request specific paper documents without revoking this authorization by contacting the Company {or Administrator} by mail, email, or telephone.

I hereby represent that I have reviewed the fraud warning notice (if applicable) on the reverse side of this application for the Group's state of domicile.

Dated at: _____ this _____ day of _____ , 20 _____

Signed for the Employer: _____ Title: _____

Separate Billing Required: ☐ Yes ☐ No
(if yes, please attach names of classifications, location addresses and contact)

We wish to be included in the Avēsis e-billing system: ☐ Yes ☐ No

WRITING BROKER'S CERTIFYING STATEMENT

I certify that I have accurately recorded on this application the information supplied by the proposed policyholder(s).

Firm Name: _____

Broker Name (print): _____ Broker Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Commission Check Payable to: _____ Firm Name: _____

Tax ID#: _____

Commission Check Payable to: _____ Broker Name: _____

SS#: _____

Broker Signature: _____ Phone: _____

This application signed: _____ this _____ day of _____ , 20 _____

APPLICATION INSTRUCTIONS

Complete this application form. Be sure to sign where indicated above.

Return the completed application form along with the first month's premium payable to FIDELITY SECURITY LIFE INSURANCE COMPANY to:

Avēsis Third Party Administrators, Inc.
P.O. Box 316
Owings Mills, MD 21117

Subsequent payments to be payable to FIDELITY SECURITY LIFE INSURANCE COMPANY and sent to:

Avēsis Third Party Administrators, Inc.
P.O. Box 842531
Los Angeles, CA 90084-2531

FRAUD WARNING NOTICE	
For residents of all states (except the following:)	Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
Alabama	Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in orison, or any combination thereof.
Arkansas, Louisiana, Rhode Island, West Virginia	Any person who 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.
District of Columbia	WARNING: It is a crime to provide false or misleading information to an insurer for the 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 applicant.
Georgia, Texas	Any person who with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.
Nebraska	Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing false, incomplete or misleading information is guilty of insurance fraud.
North Carolina	Any person with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which may subject the person to criminal and civil penalties.
Oklahoma	WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
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.
Tennessee	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
Virginia	Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

I am an officer or authorized person of <insert group name> and authorize <insert broker name>
to access <insert group name> information related to the enrollment and disenrollment, or summary health information (non-identifying information), as it relates to the insurance coverage underwritten by Fidelity Security Life Insurance Company.

Group Name

_____

Broker Name

_____

Signature

_____

Signature

_____

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☐ I am Waiving Vision Insurance

AVĒSIS ADVANTAGE VISION CARE EMPLOYEE ENROLLMENT FORM

PLEASE PRINT LEGIBLY

Underwritten by Fidelity Security Life Insurance Company Kansas City, Missouri

Policy No. VC-16

TO BE COMPLETED BY THE EMPLOYEE

Employee Last Name	*Employee First Name*	*MI*

Date of Birth	*Social Security Number*	*Sex*
/ /	- -	☐ Male ☐ Female

Street Address	*Apartment No.*

City	*State*	*Zip Code*
		-

Do you wish to cover your eligible dependents? ☐ Yes ☐ No

If yes, complete the following:

	Dependent Name	*Date of Birth*
Spouse/Domestic Partner		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /

☐ ***I would like to cover additional eligible dependents*** (PLEASE LIST ON A SECOND ENROLLMENT FORM)

By signing below, I agree to receive all documents and correspondence electronically and that I can access the internet or the email address provided. I understand that I may revoke this authorization or request specific paper documents without revoking this authorization by contacting the Company {or Administrator} by mail, email, or telephone.

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.

I authorize deductions from my earnings at the required contributions towards the cost of the coverage.

Signature	*Date* / /

TO BE COMPLETED BY THE EMPLOYER

☐ **New Enrollment**	☐ **Add** ☐ Dependents	☐ **Change** ☐ Address ☐ Name ☐ Phone ☐ COBRA	☐ **Cancel Coverage** ☐ Policy Holder ☐ Dependent(s)
Reason for Change	☐ Employment Status ☐ Qualifying Event: (PLEASE STATE) _____		
Requested Effective Date / /		*Date of Employment* / /	