VISION SERVICE PLAN
EMPLOYER APPLICATION

1. Employer Information The employer certifies that the following information is correct:

Company Name: Tax ID Number:

Street Address (not P. O. Box)

City: State: Zip:

Billing Address:

City: State: Zip:

Employer is a: ☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Other (please explain):

Company Contact Person:

Telephone: Fax: Email:

Date Business was established: (M/D/Y) Type of Business: (be specific)

2. Benefit Selection

Choose One Plan:

Signature Plan (Full Network)

- ☐ Plan A (12/24/24) w/$10 Deductible
- ☐ Plan A (12/24/24) w/ $25 Deductible
- ☐ Plan B (12/12/24) w/$10 Deductible
- ☐ Plan B (12/12/24) w/$25 Deductible
- ☐ Plan C (12/12/12) w/$10 Deductible
- ☐ Plan C (12/12/12) w/$25 Deductible

Value Plan (Reduced Network)

- ☐ Plan A (12/24/24) w/$10 Deductible
- ☐ Plan A (12/24/24) w/$25 Deductible
- ☐ Plan B (12/12/24) w/$10 Deductible
- ☐ Plan B (12/12/24) w/$25 Deductible

3. Premium Calculation

	# of Members		Rate		
Employee Only		**X**	$	=	**$**
Employee +1 dependent		**X**	$	=	**$**
Employee + 2 or more children		**X**	$	=	**$**
Family		**X**	$	=	**$**
Subtotal					**$**
Monthly Administration Fee					**$15.00**
Grand Total					**$**

Please Make Check Payable to BAC

4. Employee Eligibility

A. Choose One:

☐ 1. VSP participation and contribution matches employer-sponsored medical plan participation exactly. All eligible employees and dependents must be enrolled continuously under both plans to remain eligible under vision program.

Name of medical carrier that participation will match_____

☐ 2. VSP participation and contribution matches employer-sponsored dental plan participation exactly. All eligible employees and dependents must be enrolled continuously under both plans to remain eligible under vision program.

Name of dental carrier that participation will match _____

☐ 3. VSP participation is 100% employer paid and all eligible employees and eligible dependents are enrolled.

☐ 4. VSP participation is 100% employer paid and all eligible employees and no dependents are enrolled.

The waiting period for future employees is first of the month following:

☐ DOH ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months

Are you waiving the waiting period for new hires at initial enrollment? ☐ Yes ☐ No

Are you acquiring new medical/dental coverage at the same time? ☐ Yes ☐ No

Do you have COBRA employees? ☐ Yes ☐ No

Do you have employees in their COBRA election period? ☐ Yes ☐ No

If so, please list their names and provide us with a copy of their COBRA election form and VSP application at this initial enrollment. _____

_____

_____

B. Effective Date:

Requested effective date:_____

Actual effective date will be assigned by Beneficial Administrative Company (BAC) if application is accepted. Only First of the month effective dates are available.

---

5. Participation Agreement

We, the undersigned group understand that we are applying for membership in the Supplemental Vision Benefit Employer Trust ("Trust"). Vision Service Plan ("VSP") has issued a master policy to the Trust which provides vision benefits to employer groups and their eligible employees and dependents. We certify that all information provided with respect to the company and its employees/members is accurate and complete. If not complete, VSP and/or BAC reserve the right to reject this application.

We, the undersigned group, understand that we have an obligation to ensure that all persons offered benefits meet eligibility requirements and that coverage is offered to every eligible person. We understand that we will be liable for any claims incurred during any period in which we do not meet the participation and maintenance requirements. We understand that VSP and/or BAC will rely on the representations contained in this document and any others, such as applications, which we provide in determining whether to accept us as an eligible group.

It is understood that coverage for any benefits shall not commence until a completed Employer Application has been approved by VSP and/or BAC, its authorized agents, or representatives; the first month's premium for the benefit plan has been paid; all completed employee applications have been submitted; and notice of said approval has been transmitted in writing to us. We certify that the answers on any and all applications are true and understand that coverage may be rescinded should it be determined at a future date that there are misstatements in the applications.

Some of the contracts Warner Pacific Insurance Services Inc. ("Warner Pacific") holds with insurance carriers provide for payment of incentives, compensation, excess surplus and bonuses ("compensation"). In the sole and exclusive discretion of Warner Pacific, such compensation may be retained by Warner Pacific or distributed to other parties. Such compensation will not be returned to you as the employer/plan sponsor. Any vision benefits claims submitted under your policy/certificate will be paid without regard to such compensation.

Arbitration Agreement: We understand that any dispute between us and VSP and/or BAC must be resolved through binding arbitration if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court and not by lawsuit or court process, except as California provides for judicial review of arbitration proceedings.

Dated at _____ on the_____ day of _____in the year _____.

By_____
(Signature of Company Officer/Owner)

_____
(Printed Name of Company Officer/Owner)

Title_____

6. Agent's Certification

I hereby certify that I am not aware of any information that has been withheld from this application by the client and which may have bearing on this risk.

I hereby certify that I have advised the client not to terminate any existing coverage until they have received written notification from VSP and/or BAC that the coverage being requested by this application is accepted.

Writing Agent's Name (Print or type):_____

Agency Name:_____

Make commission checks payable to Agent or Agency? _____

Telephone:_____ Fax:_____

Email: _____

Agent Street Address:_____

City:_____ State:_____ Zip:_____

Agent Signature:_____ Tax ID Number:_____ Date:_____

SEND ALL ENROLLMENT MATERIALS TO:
Warner Pacific Insurance Services
32110 Agoura Road
Westlake Village, CA 91361-4026
(800) 801-2300 – Fax (800) 609-0111