

Vision Care



Sold Case Form

Print or Type

GROUP PROFILE

Legal Name of Employer: _____

Requested Effective Date of Coverage: _____ IRS Reporting Number: _____

Street Address: _____ P.O. Box (If Applicable): _____

City: _____ State: _____ Zip: _____ County: _____

Phone Number: _____ Nature of Business: _____ SIC: _____

Business Type: Corporation Association Partnership Sole Proprietorship Other _____

Other Locations or Affiliated Companies/Subsidiaries to be Included: No Yes, List name(s) and location(s): _____

Main Contact: _____ Title: _____

Phone Number: _____ Fax Number: _____ E-Mail: _____

ELIGIBILITY

Number of Eligible Employees: _____ Number of Enrolled Employees: _____

Are Dependents Covered: Yes No

Dependents Coverage Age Limit: To age 19, students to age 23 Other: _____

Domestic Partner Coverage: Yes No

Type of Funding

True Group (Minimum 50% Employer contribution and 75% employee participation requirement or 10 lives, whichever is greater)

Non-Contributory (100% Employer Paid and 100% employee participation)

Voluntary Group (Employee Paid and at least 20% participation requirement or 5 lives, whichever is greater)

Eligibility Waiting Period

New Employees: First day of month coinciding with or following _____ days of employment.

Other _____

Present Employees: All are eligible immediately, regardless of length of service.

Only those who have satisfied the waiting period are eligible. (Provide hire dates.)

Eligibility Hours Worked Per Week

Full time employees working 30 or more hours Other _____

TYPE OF COVERAGE (A copy of the proposal and rate pages must be attached.) Please choose one of the following frequency options:

Frequency: (Exam/Lenses/Frames/Contact)

(12/12/24/12) (12/12/12/12) (12/12/24/24) (24/24/24/24) Exam Only (12) Materials Only Other: _____

(continued on back)



Retail Program Allowances: Frame: \$72 \$82 \$90 \$100 \$102 \$130

Contact Lenses: \$60 \$75 \$100 \$105 \$115

Other: Frames: _____ Contact Lenses: _____

Copay(s): Exam \$____/ Frames \$____/ Lenses \$____/ Contacts \$____

Non-Participating Schedule of Allowances: Standard Other (Attached)

Are benefits requested subject to union negotiation? No Yes (Attach a copy of the current union contract.)

RATES

EE Only: \$_____ EE + 1 (Spouse OR Child): \$_____ EE + Family (Spouse AND Child(ren)): _____

Rate Guarantee: 24 months Other : _____ Commission: _____ %

ADMINISTRATIVE

Will this insurance replace similar coverage? No Yes (Show the name of carrier and dates of coverage)

Carrier: _____ Effective Date: ____/____/____ Termination Date: ____/____/____

Membership Maintenance: Tape (Attach Format or indicate IS Contact Person below) Manual

Electronic Transfer (Attach Format or indicate IS Contact Person below)

Please provide an Eligibility and Billing Service Contact Person:

Eligibility Contact: _____ Title: _____

Phone Number: _____ Fax Number: _____ E-Mail: _____

Billing Contact: _____ Title: _____

Phone Number: _____ Fax Number: _____ E-Mail: _____

Deliver Administration Package to: Group Broker A&H Representative

THE EMPLOYER UNDERSTANDS AND AGREES:

- The requested insurance will not become effective unless Chartis receives and approves the application.
- Being actively at work is a requirement for coverage.
- No waiver or change will bind Chartis unless signed by our officer.

Signature: _____ Date: ____/____/____

Name and Title (Print) _____

AIG Representative: _____ Region/Branch Code: _____

AGENT INFORMATION

Company: _____ Representative: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone Number: _____

IRS Reporting Number: _____ Dept. of Insurance License Number: _____

To be completed by Chartis:

Policy Number	Effective Date	Check Received <input type="checkbox"/> Yes <input type="checkbox"/> No	Check Amount	U/W Approval	Chartis Producer Code
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