GROUP VISION APPLICATION

Mail Completed Form to:
BLOCK VISION OF TEXAS, INC.
6737 West Washington Street, Suite 2202
Milwaukee, Wisconsin 53214

Group No. _____

Legal Company Name_____ Phone (_____)_____ e-mail _____

Address _____Fax (_____)_____

City/State/Zip_____ SIC Code _____

Contact for Administration & Eligibility _____Phone (_____)_____ e-mail _____

Contact for Billing _____Phone (_____)_____ e-mail _____

Employees: _____ # Eligible _____ # of Employees with Dependents _____

Group Effective Date: _____ / _____ / _____
A check for the first month's premium and other applicable fees must be attached to begin processing. Eligibility data will be submitted using: ☐ Enrollment forms ☐ E-mail or electronic media

Plan Details:
Plan: ☐ Full-Service ☐ Exam-Only
Exam Copay: $ _____
Retail Frame Allowance: ☐ $____ *or* ☐ **Total Eyewear Allowance** $____ Frequency ____
Rate-tier structure: ☐ 2-rate ☐ 3-rate ☐ 4-rate
Is the Plan: ☐ Employer Paid (Company pays 50% or more of premium cost)
☐ Voluntary (Company pays less than 50% of premium cost)

Frequency (Exam/Lens/Frame/Contacts)	
Please check one:	
☐ Platinum	(12/12/12/12)
☐ Gold	(12/12/24/12)
☐ Silver	(12/24/24/24)

Eligibility:
Permanent, full-time employees working _____ hours per week are eligible for coverage (Standard: 30 hours).
An eligible employee must have been actively at work on a full-time basis for _____ months in order to be eligible for coverage.
An eligible dependent must be less than ____ yrs. old or less than _____ yrs. old if a full-time student. (same as employer health plan)
Participation: Depending on group size and coverage elected, specific participation requirements will apply. Participation must be met before the coverage can be effective and must be maintained continuously while coverage is in force to prevent cancellation of coverage.

I understand and agree that audits may be made by Block Vision of Texas, Inc. now and in the future to verify the number and names of full-time employees of this company. I will furnish with application, and upon any future request, a current census and State Quarterly Unemployment Tax Report, and any other information requested.

Please send Membership Materials and Enrollment Materials to (CHECK ONE):

☐ Group Attn: _____Phone: (_____)_____
☐ Broker or Agent

Broker or Agent Name/Address/Phone/ Tax I.D. (broker/agent receiving commission) _____
_____

Agency Name/Address/Phone/Tax I.D. (agency receiving commission) _____
_____

The information contained herein describes the essential provisions of the elected coverage(s) discussed between the above client and an authorized Block Vision of Texas, Inc. representative. By signing this form, both parties agree that these are the essential provisions the client is purchasing. The details of this form may be changed by either party with mutual agreement.

Signed: _____ _____/_____/_____
Name Title Date

Block Vision of Texas, Inc. Representative _____ _____/_____/_____
Date