APPLICATION FOR GROUP VISION INSURANCE
AMERICAN MEDICAL AND LIFE INSURANCE COMPANY
35 BROADWAY, HICKSVILLE, NY 11801

Administered by: Block Vision, Inc., P.O. Box 14035, Milwaukee, Wisconsin 53214-0035 PH: 866-265-0517

Application is hereby made to American Medical and Life Insurance Company of Hicksville, New York for a contract of Group Vision Care Insurance based on the following statements and representations.

Group Number: _____

1. Group Applicant (legal company name): _____

2. Address: _____ Phone: _____

   Contact for Administration/Eligibility: Name/Title _____ Phone _____ E-mail _____

   Contact for Billing: Name/Title_____ Phone _____ E-mail _____

3. Eligible Employees: Full Time Employees working a minimum of ❑ 30 ❑ 35 ❑ 40 hours per week after completing ❑ 30 ❑ 60 ❑ 90 days of service. Eligible dependent must be less than ____ years old, or less than ___ years old if a full-time student.

4. # Employees:_____ # Eligible Employees:_____ # with Dependents:_____ # Eligible Employees enrolled: _____

5. The contract shall be made effective at 12:01 a.m. on: _____ and all insurance months shall be calculated from the effective date. Contract term: ❑12 ❑ 24 ❑ 36 months

6. Premiums are to be paid monthly in advance, and are for each employee (enrollee) and dependents as listed on the attached Addendum. A check for the first month's premium and other applicable fees must be attached to begin processing. Thereafter, the premium for this policy is due on the 1st day of each month.

7. Plan Details:

   Plan Type: ❑ Full-Service ❑ Exam-Only ❑ Eyewear-Only
   ❑Single Copay: $ ____ ❑Dual Copay: $____ $____
   Retail Frame Allowance: ❑ $_____ *or* ❑ Total Eyewear Allowance $_____
   Rate-tier structure: ❑ 2-rate ❑ 3-rate ❑ 4-rate

   Is the Plan: ❑ Employer Paid (Employer pays 100% of premium)
   ❑ Voluntary (Employer pays less than 100% of premium)

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

IT IS AGREED THAT this insurance will not become effective unless this application is received and approved by the AMERICAN MEDICAL AND LIFE INSURANCE COMPANY.

WARNING: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicant's Signature _____ Title _____ Date _____

Accepted by AMERICAN MEDICAL AND LIFE INSURANCE COMPANY, of Hicksville, N.Y.

Signature _____ Title _____ Date _____

Agent Signature: _____ Agent # _____ Date _____

Printed Agent Name/Address/Phone/E-mail/Tax ID (agent or firm receiving commission):_____
_____

Please send Membership Materials and Enrollment Materials to (CHECK ONE):
❑Group Attn: _____ Phone: _____ ❑Agent