GROUP MASTER APPLICATION FOR GROUP VISION CARE INSURANCE POLICY
Opticare of Utah
1901 West Parkway Blvd., Salt Lake, City, UT 84119
800-363-0950 (www.opticareofutah.com)

1. Employer Information – Group Policyholder	
Legal Name of Group Policyholder:	
Address:	
Billing Address (if different):	
Phone Number:	E-mail:
Type of Business:	
Name of Human Resources Contact:	Phone Number:

2. Group Vision Care Plan(s) Selected:							
Plan:		**Plan:**		**Plan:**		**Plan:**	
Proposed Effective Date:		**Proposed Effective Date:**		**Proposed Effective Date:**		**Proposed Effective Date:**	
Monthly Premium:		**Monthly Premium:**		**Monthly Premium:**		**Monthly Premium:**	
Single	$	Single	$	Single	$	Single	$
Two-Party	$	Two-Party	$	Two-Party	$	Two-Party	$
Family	$	Family	$	Family	$	Family	$

3. Employer Contribution: ☐ None – Coverage is Voluntary ☐ Employer Contribution
Employer Contribution for Employee: $_____ or _____% per month
Employer Contribution for Dependents: $_____ or _____% per month

4. Enrollment Eligibility: *Please indicate the employee eligibility requirements for enrollment under the group policy.*	
Enrollment under the group policy will include (*select all that apply):* ☐ All Full-Time Active Employees ☐ All Part-Time Active Employees ☐ Other: _____ ☐ Dependents	
Eligibility Requirements (please specify):	
Annual Open Enrollment Period: ☐ Yes ☐ No. If "Yes", specify the annual enrollment period date: _____ *(Please Note: You may only have one open enrollment period per year.)*	
Total Number of Employees (including part-time employees):	Total Number of Eligible Employees (including part-time employees):

5. Remarks

6. Representations – Agreement

I agree that Opticare of Utah may use the name of my business, address and the fact of my participation in this agreement for purposes of publicizing Opticare of Utah's PPO Network, preparing bids for contracts and other similar marketing purposes. Yes [ ] No [ ]

I agree that: (1) the statements and answers given in this application are true, complete, and correctly recorded to the best of my knowledge and belief; (2) this application will be part of the group policy for which I apply; (3) the group policy is a one year contract that is guaranteed renewable in accordance with the terms of the group policy; (4) I will notify the Insurer if any statements or answers given in this application change prior to policy delivery; and (5) I have received the Outline of Coverage.

I understand and agree that the policy is to remain in force for a one year period beginning on the effective date of the policy; I understand that this policy is guaranteed renewable each year on the anniversary date of the policy.

I understand and agree that I may only elect one open enrollment period per year for the group policy. I understand and agree that the annual enrollment period I indicated under section 4 of this Application will be applied every year, unless I give a written request to Opticare of Utah to change the annual open enrollment period date at least 60 days in advance of the next Policy Anniversary Date. I understand and agree that the requested change in the annual open enrollment date upon approval by Opticare of Utah will be applied to the next policy year that begins on that Policy Anniversary Date.

I understand and agree that the first month's estimated premium and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this application ***before*** action can be taken on this application. Coverage is not in effect unless and until I receive notification of acceptance from Opticare of Utah. If this application is declined, Opticare of Utah will return the premium deposit submitted with this application. If my coverage is approved, premium is payable in advance of the due date.

I understand that Opticare of Utah will rely on the information I provide in determining eligibility for coverage, setting premium rates, and other purposes, and that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums, or other consequences as permitted by law. I agree that Opticare of Utah shall be entitled to rely on the most current information in its possession regarding eligibility of employees and their dependents in providing coverage under the policy. I understand and agree that I am responsible for notifying Opticare of Utah promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of newly eligible employees or dependents.

I understand that the Certificate of Coverage or Summary Plan Description, and other documents, notices and communications regarding the coverage indicated on this application may be transmitted electronically or by mail to me from Opticare of Utah.

No licensed insurance agent is authorized to: (a) make or modify contracts; (b) waive any Insurer rights or requirements; and (c) waive any information the Insurer requests.

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 may be guilty of a crime and may be subject to fines and confinement in prison

The policy provides vision benefits only. Review your policy carefully.

Signature of Group Policyholder (Employer)	Date signed
State in which Group Policy will be delivered	State in which Group Policyholder signed Application
Printed Name of Licensed Insurance Agent	Signature of Licensed Insurance Agent
Agent License Number	