EyeMed Vision Care Enrollment Kit

Instructions

This packet includes all necessary paperwork for enrollment with EyeMed Vision Care. EyeMed requires a minimum of 10 enrolled employees.

We recommend that broker appointment paperwork be submitted in advance of case submission.

Checklist

	document/item	doc #	revised
☐	Employer Application	M-9083/M-9093	03-14
☐	Signed Commission Agreement		
☐	Signed Original Proposal		
☐	Online Group Management Registration Form *(optional)*		04-09
☐	Producer Appointment with EyeMed (via Fidelity Security)		
☐	Employee Enrollment/Change Form		
☐	Check payable to EyeMed Vision Care		

Contact

Submit Paperwork to

Kilpatrick Companies, Ltd
1050 Wilcrest Dr.
Houston, TX 77042

Call

800-833-8478

Internet

www.kilpatrickcos.com

Application for Vision Care Benefits

Underwritten by Fidelity Security Life Insurance Company
Kansas City, Missouri

I. GROUP INFORMATION

Group Name: _____ Tax ID#: _____

DBA Name (If other than above): _____

Business Address: _____ City _____ State: _____ ZIP: _____

Mailing Address: _____ City _____ State: _____ ZIP: _____

Primary Contact: _____ Title: _____

Phone Number: ( ) _____ Fax Number: ( ) _____

E-mail Address: _____

Type of Business: ☐ Proprietorship ☐ Corporation ☐ Other (Specify): _____

Service Area: ☐ National (United States – does not include Puerto Rico) ☐ State Specific (List) _____

PLEASE NOTE THE FOLLOWING TYPE BUSINESSES REQUIRE PRIOR CARRIER APPROVAL:

☐ MEWA ☐ PEO ☐ Trust ☐ Union

If any subsidiary or affiliated companies are to be insured or any Employees/Members are working at a location other than the business address above, please explain. _____

_____

Billing Contact Name: _____ Phone: ( ) _____

Billing Address: _____ City: _____ State: _____ ZIP: _____

If you have subsidiaries, affiliated companies, or divisions who use another name and will be covered by this plan, AND require separate billing invoices, please attach the following information on a separate sheet of paper signed by you: • Name • Address • Billing Contact & Phone Number

Will this plan replace any existing coverage? ☐ Yes ☐ No

If "Yes," indicate name of existing insurer:

Name: _____

If "Yes," are any Employees/Members on COBRA continuation? ☐ Yes ☐ No How many? _____

Do you intend to offer Employees/Members COBRA continuation? ☐ Yes ☐ No

II. PLAN SELECTION

Please refer to the attached proposal page. Services are provided by EyeMed Vision Care.

III. PREMIUMS

Group's Premium Contribution for*: Employees/Members: _____ % Dependents: _____ %

Employee's/Member's Premium Contribution for: Employees/Members: _____ % Dependents: _____ %

Are Employee/Member and Dependent premiums paid through a Section 125 Plan? ☐ Yes ☐ No

Are Employee/Member and Dependent premiums collected via payroll deduction? ☐ Yes ☐ No

Premiums shall be payable at the rates included on the attached proposal page.

**If the Group's contribution percentage is changed or the number of eligible Employees/Members increases or decreases, premium may be adjusted as allowed under the Policy. The premium may be adjusted at the end of the calendar month in which the change occurred.*

IV. ELIGIBILITY

Number of Employees/Members: _____ Number Applying: _____

Number of Dependents: _____ Number of Retirees: _____

Are Domestic Partners covered under this Plan*? ☐ Yes ☐ No

Dependent Children Covered to Age*: ☐ 25 ☐ 26** ☐ Other _____

Dependent Children Covered if Full-Time Student*? ☐ Yes ☐ No

If "Yes," Dependent Full-Time Students Covered to Age*: ☐ 26 ☐ 27 ☐ Other _____

**Unless state law has different requirements.*

***Dependent Children covered to age 26 regardless of financial dependency, residency, student status or marital status.*

Eligibility Reporting Contact (produces the eligibility file): _____

Address (if different from Group): _____

City: _____ State: _____ ZIP: _____

E-mail Address: _____ Phone: ( ) _____ Fax: ( ) _____

Eligibility Authorization Contact (Benefits Administrator or Third Party Administrator responsible for verifying vision election for Employees/Members):

Name: _____ Phone: ( ) _____

Days/Hours of Availability: _____ E-mail Address: _____

PROBATIONARY PERIOD

For New Employees/Members: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days ☐ Other _____

Probationary Period is waived for present Employees/Members: ☐ Yes ☐ No

Number of Employees/Members who have not yet completed the probationary period: _____

V. EFFECTIVE DATE

This plan will become effective at 12:01 a.m. Local Time at the Group's address herein, on the first day of _____, 20 _____, provided all of the following have been completed prior to this effective date:

A. This application has been received and accepted by the Company (must be submitted 30 days in advance of the effective date).

B. EyeMed has been furnished a working file of all eligible Employees/Members, according to the layout guidelines. It is understood and agreed that EyeMed may rely on this information to provide services to individuals designated as eligible.

The Group hereby makes application to Fidelity Security Life Insurance Company for Vision Care Benefits. The Group agrees to maintain and furnish any records necessary to administer this plan and to forward premiums monthly.

The Group certifies that all the information shown on this application and any attachments are correct and complete as of the date this application is signed. The Group understands that the Company intends to rely on this information in determining whether or not the enrolling Employees/Members and their Dependents may become insured. It is further understood and agreed that **NO INSURANCE WILL BECOME EFFECTIVE UNTIL APPROVED BY THE COMPANY**; and that no field representative of the Company has the authority to modify any conditions of the application or the Policy by making any promise or representation. It is understood that the insurance as to any Employee/Member will not become effective on the date insurance should otherwise become effective if he or she is not at work on such date performing all duties of his or her occupation and otherwise meets the requirements of the Company.

Any person who with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Dated at: _____ this _____ day of _____, 20 _____

Signed for the Group: ► _____ Title: _____

VI. COMPANY DISPLAY NAME (Your Group name as it should appear to your employees)

Company Name _____
(Maximum of 30 characters, including punctuation and spacing.)

ATTENTION: THE DEPARTMENT OF INSURANCE REQUIRES THAT ONLY THE BROKER AND/OR GENERAL AGENT WHO SOLD THE PRODUCT AND HOLDS A VALID LIFE AND HEALTH LICENSE MAY COMPLETE THE CERTIFYING STATEMENT

WRITING BROKER'S CERTIFYING STATEMENT

I certify that I have accurately recorded on this application the information supplied by the applicant, if such information has been provided directly to me for recording purposes, and I am properly licensed in the state in which the Group is domiciled.

Firm Name (print): _____ Tax ID No.: _____

Broker's Name (print): _____ SS#: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: ( ) _____ Fax: ( ) _____

Primary Contact: _____ Secondary Contact: _____

Title: _____ Title: _____

E-mail Address: _____ E-mail Address: _____

Commission checks payable to: ☐ Firm ☐ Broker

Broker's Signature: ► _____

WRITING GENERAL AGENT'S CERTIFYING STATEMENT

I certify that I have accurately recorded on this application the information supplied by the applicant, if such information has been provided directly to me for recording purposes, and I am properly licensed in the state in which the Group is domiciled.

Firm Name (print): _____ Tax ID No.: _____

General Agent's Name (print): _____ SS#: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: ( ) _____ Fax: ( ) _____

Primary Contact: _____ Secondary Contact: _____

Title: _____ Title: _____

E-mail Address: _____ E-mail Address: _____

Commission checks payable to: ☐ Firm ☐ General Agent

General Agent's Signature: ► _____

FIDELITY SECURITY LIFE INSURANCE COMPANY

BROKER COMMISSION SCHEDULE

GROUP NAME:

EFFECTIVE:

Commission Percentage

Broker Name: _____

Commission **%**

Broker Agency Name: _____

Broker Signature: _____

EyeMed Online Group Management System
Client Account Registration for Member Enrollment/Disenrollment Information
Fixed Fee and Discount Plans

Client Account Name		
Client Account Owner (enter below)	**Plan Name**	**Plan Number**

The EyeMed Online Group Management System is an administrative tool that enables the Client to register account users to view, edit and maintain member enrollment/disenrollment, protected health information, for the EyeMed vision plan. The Online Group Management System is for the Client's benefit to access member enrollment and disenrollment information.

To register and have access to the EyeMed Online Group Management System, the client must complete the above information and sign below.

The Client is responsible to define one Account Owner for each plan registered for the EyeMed Online Group Management System. The Client Account Owner is the individual designated by the Client to be responsible for assigning and maintaining user roles and responsibilities related to the ability to view, edit and/or maintain member enrollment/disenrollment, protected health information, for the plan. EyeMed will have the responsibility to add and delete Client Account Owners based on written direction received from the Client.

The Client Account Owner will have rights to view and/or maintain member enrollment/disenrollment, protected health information, for the plan. Each Client Account Owner will have rights related to all areas of functionality available via the EyeMed Online Group Management System.

The Client Account Owner will be responsible for registering individuals within the Client's organization as Account Users for a defined plan. Brokers and/or Third Party Administrators involved with the plan may be registered as Account Users if deemed appropriate by the Client Account Owner. Client is responsible for obtaining a Business Associates Agreements if the Client chooses to register third parties such as brokers or third party administers as Account Users to assist Client Account Owner with health plan operations.

The Account Users have the right to view and/or maintain member enrollment/disenrollment, protected health information, for the plan. Each Client Account User will have defined rights related to the specific areas of functionality available via the EyeMed Online Group Management System. The Client Account Owner will have the responsibility to add and delete users as required by the client.

As signatory for the client, I certify that the above information is correct and complete. I understand that EyeMed Vision Care intends to rely on this information and will grant the individuals listed above as Client Account Owners with the ability to view and maintain member enrollment/disenrollment, protected health information, related to the plans listed above. The Client has approved for this individual to be responsible for assigning and maintaining Account User roles and responsibilities related to the ability to view and/or maintain member enrollment/disenrollment, protected health information, for the plan as appropriate. Account User roles and responsibilities will be assigned appropriately based on the individual's role within the client's organization. Client acknowledges that EyeMed reserves all rights to audit the use of the Online Group Management System by client's representatives and discontinue, in its sole discretion, any Client Account Owner or Account Users at any time, with or without notice.

Name: _____

Company Name: _____

Title: _____

Date: _____

Signature: _____

EyeMed Online Group Management System
Terms and Definitions

Client:
The Client is the Plan Sponsor or entity that has vision benefits with EyeMed. The EyeMed Online Group Management System Client Account Registration Form and all future notification of changes to defined Client Account Owners must be signed and submitted by the person entitled to contract on behalf of the entity.

Client Account Owner:
Individual designated by the Client to be responsible for assigning and maintaining user roles and responsibilities related to the ability to view and/or maintain member enrollment/disenrollment, protected health information, for the plan. EyeMed will have the responsibility to add and delete Client Account Owners based on written direction received from the Client.

Client Account Owner will be responsible for registering individuals within the Client's organization or third party individuals who have been granted rights to view and/or maintain member enrollment/disenrollment, protected health information, related to the defined plan. The Owner may register brokers and/or Third Party Administrators involved with the plan as Account Users if appropriate.

Account User:
Individual designated by the Client Account Owner to have the right to view and/or maintain member enrollment/disenrollment, protected health information, for the plan. Each Account User will have defined rights related to the specific areas of functionality available via the EyeMed Online Group Management System. The Client Account Owner will have the responsibility to add and delete users as required by the client.

Functionality Available

Member Maintenance
Maintain Enrollment/Disenrollment Data: Access to enrollment/disenrollment, protected health information, of the members. User has the ability to add, change or delete member enrollment/disenrollment information for the defined plan.

View Enrollment/Disenrollment Data: Access to enrollment/disenrollment, protected health information, of the members. User can view all member enrollment information for the defined plan.

Reports
View Premium Invoice Data: Access to enrollment/disenrollment, protected health information, of the members. User can view monthly premium invoice for the plan and has ability to view or download monthly roster of enrolled members.

Member Search
View Member Information and/order Replacement ID Card: Access to enrollment/disenrollment, protected health information, of the members. User can view member information, order replacement ID card, view list of related members and view summary of member benefits.

Enrollment/Change Form

Please print in all capital letters using blue or black ink. Please complete all sections.
Required sections are marked with an *.
Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri

Employer Information: to be completed by Employer

Employer Name*

Effective Date*^ / /

Group Number*

Subgroup*

Location Code

^Date set by employer in accordance with EyeMed proposal. Employer also sets effective date for new adds during contract period.

Employee Information: to be completed by Employee

Change Type*: ☐ Add ☐ Term ☐ Update Member ID:

Last Name*

Date of Birth* / /

First Name*

MI

Gender* ☐ Male ☐ Female

Phone Number ( ) -

Street Address*

City*

State*

Zip Code*

Social Security Number*^ - -

^Last four digits of Employee's Social Security Number are required.

Employee Email Address:

Family Information: to be completed by Employee. Only eligible dependents may be enrolled.

Dependent 1

Change Type*: ☐ Add ☐ Term ☐ Update

Relationship*: ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Domestic Partner

Last Name*

Gender*: ☐ Male ☐ Female

First Name*

MI

Social Security Number - -

Date of Birth* / /

Dependent 2

Change Type*: ☐ Add ☐ Term ☐ Update

Relationship*: ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Domestic Partner

Last Name*

Gender*: ☐ Male ☐ Female

First Name*

MI

Social Security Number - -

Date of Birth* / /

Dependent 3

Change Type*: ☐ Add ☐ Term ☐ Update

Relationship*: ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Domestic Partner

Last Name*

Gender*: ☐ Male ☐ Female

First Name*

MI

Social Security Number - -

Date of Birth* / /

Dependent 4

Change Type*: ☐ Add ☐ Term ☐ Update

Relationship*: ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Domestic Partner

Last Name*

Gender*: ☐ Male ☐ Female

First Name*

MI

Social Security Number - -

Date of Birth* / /

Employee Signature*: _____ Date*: / /

For additional dependents, please complete a second form.