



AVESIS VISION PLANS

FIDELITY SECURITY LIFE INSURANCE COMPANY
Kansas City, Missouri

Policy No. VC-16

GROUP APPLICATION FOR AVESIS VISION BENEFITS

I. EMPLOYER INFORMATION

Employer Name: _____ Tax ID# _____

DBA Name (if other than above): _____

Business Address: _____ City _____ State _____ Zip _____

Mailing Address (if other than above): _____ City _____ State _____ Zip _____

Key Contact _____ Title _____

Phone Number () _____ Fax Number () _____

Executive Contact _____

Phone Number () _____ Fax Number () _____

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

If any subsidiary or affiliated companies are to be insured or any Employees are working at a location other than the address above, please explain:

Separate Billing required? _____ Yes _____ No (if yes, please attach names of classifications, location addresses and contact)

Will this plan replace any existing coverage? Yes No If "Yes", indicate name and address of existing insurer:

Name: _____ Address: _____

City _____ State _____ Zip _____

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

Effective date of existing coverage _____

Termination date of existing coverage (if applicable) _____

Number of full-time Employees _____ Number applying _____

II. PLAN SELECTION:

AVESIS Standard Plan AVESIS Premier Plan AVESIS Diamond Plan

Co-payment: \$ _____ Examination \$ _____ Materials

	<u>NO. OF EMPLOYEES</u>		<u>RATE</u>		<u>TOTAL REMITTANCE</u>
Employee Only Rate	_____	X	\$ _____	=	\$ _____
Employee + One	_____	X	\$ _____	=	\$ _____
Employee + Family	_____	X	\$ _____	=	\$ _____
			TOTAL	=	\$ _____

III. PREMIUMS

Employer's Premium Contribution for: Employees: _____ Dependents: _____

Are Employee and Dependent premiums being paid through a Section 125 Plan? Yes No

Are Employee and Dependent premiums being collected by payroll deduction? Yes No

Premium received with application: _____

Premiums shall be payable in advance at the rates set forth in the following Schedule of Premiums.

IV. ELIGIBILITY Choose One:

PROBATIONARY PERIOD? For new Employees: 30 days 60 days 90 days 180 days

Other _____

Probationary Period is waived for present Employees Yes No

ELIGIBLE CLASS

The Employees eligible for insurance under the Policy shall be all the full-time Employees of the above-named Employer and each Employee's Dependents. If both husband and wife are Employees, either the husband or wife, but not both, may elect coverage for their Dependents. Eligible Dependents may be added to the Policy on any premium due date.

As used here, full-time Employee means an Employee who is performing all the usual duties of his or her position at the Employer's usual place of business at least _____ or more hours per week. A part-time Employee is an Employee who does not meet this definition.

Dependents may not be included as Eligible Persons unless the Dependent's parent or spouse is covered under the Policy.

The Employees eligible for insurance under the Policy shall be all the Employees of the above named Employer, and each Employee's Dependents. If both husband and wife are Employees, either the husband or wife, but not both, may elect coverage for their Dependents. Eligible Dependents may be added to the Policy on any premium due date.

The Employees eligible for insurance under the Policy shall be _____

DATE ELIGIBLE

1. Each Employee included in an Eligible Class on the Policyholder's Effective Date will be eligible on that date, provided the Employee has completed any required probationary period shown above.
2. Each Employee included in an Eligible Class on the Policyholder's Effective Date, and who had partially satisfied the required probationary period prior to the Policyholder's Effective Date, will be eligible on the first day of the calendar month coinciding with or next following the date of completion of the probationary period.
3. Each Employee who enters an Eligible Class AFTER the Policyholder's Effective Date will be eligible on the first day of the calendar month coinciding with or next following:
 - a. completion of any required probationary period; or
 - b. the Employee's date of employment, if a probationary period is not required.

EMPLOYEE ENROLLMENT

1. Each Employee may request coverage for his or her eligible Dependents.
2. The Company reserves the right, based upon Our underwriting procedures, to require that the eligible Employee and/or eligible Dependent of a Policyholder submit an enrollment form and agree to pay any premium contribution, if required, before coverage will become effective for the Dependent.

PARTICIPATION REQUIREMENT

The Policyholder is required to maintain the minimum participation requirements of the Company as follows:

When a contribution is not required by the Employee, then 100% of the eligible Employees must be covered at all times. At least 10 Employees must be covered on the Policy's Effective Date.

V. EFFECTIVE DATE

It is desired that the policy shall become effective at 12:01 A.M. Standard Time at the Employer's address herein, on the first day of _____, 200__, provided this application shall have been accepted by the Company.

The Policy, if issued, shall be effective for a term of two (2) years.

VI. APPLICATION INSTRUCTIONS

Complete this application form. Be sure to sign at the bottom.

Return the completed group application form along with all enrolling Employee applications and the first month's premium PAYABLE TO DENTAQUEST MANAGEMENT to:

DentaQuest Management
4061 Powder Mill Road, Suite 325
Calverton, Maryland 20705-3149

The Employer hereby makes application to Fidelity Security Life Insurance Company for AVESIS Vision Benefits. The Employer agrees to maintain and furnish any records necessary to administer the plan, and to pay premiums monthly in advance.

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

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

Signed for the Employer: _____ Title: _____

WRITING BROKER'S CERTIFYING STATEMENT

I certify that I have accurately recorded on this application the information supplied by the proposed policyholder(s).

Firm Name: _____

Broker Name: (print) _____

Broker Number: _____

Address _____ City _____ State _____ Zip _____

Commission Checks Payable To: _____ Firm Name Tax I.D.# _____

Commission Checks Payable To: _____ Broker Name Social Security _____

Broker Signature _____ Phone _____

This application signed this _____ day of _____, 20_____.