

Application for Vision Care 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: _____

Correspondent: _____ Title: _____

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:

Will this plan replace any existing coverage? Yes No

If "Yes," indicate name and address of existing insurer:

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Effective date of existing coverage: _____

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

Termination date of existing coverage (if applicable): _____

Number of Full-time Employees: _____ Number Applying: _____

PROBATIONARY PERIOD

For New Employees: 30 days 60 days 90 days 180 days Other _____

Probationary Period is waived for present Employees: Yes No

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

II. PLAN SELECTION

Standard Enhanced Premium Other

Please see attached Quote Sheet for the Benefit plan selected

III. PREMIUMS

Contribution towards premium Yes No

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

Employee'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: _____

Number of Participants

Employees without dependents: _____

Employees with dependents: _____

Note: Please attach a list of all participants to this application (the list may be a hard copy or on a diskette).

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

IV. SCHEDULE OF PREMIUMS

Please see attached Quote Sheet for Premium Information.

V. ELIGIBILITY

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.

No Part-time Employee, or his or her Dependents, may be included as Eligible Persons.

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 30 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.

DEFERRED 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 below.
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 him or herself and 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 Employee and/or Dependent.

DELAYED ENROLLMENT

Each Employee who waives or declines insurance when he or she becomes eligible will not be eligible again until the next open enrollment for the plan. If insurance is waived or declined for eligible Dependents, then those Dependents will not become eligible again until the next open enrollment for the plan.

PARTICIPATION REQUIREMENT

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

If part of the premium is derived from funds contributed by the insured Employees, at least 30% of the eligible Employees must elect to make the required contribution and at least 10 Employees must be covered on the Policy's Effective Date.

When a contribution is not required by the Employee, then 100% of the eligible Employees must be covered at all times.

VI. 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 _____ day of _____, _____, provided this application shall have been accepted by the Company.

The Policy, if issued, shall be effective for a term of one year.

The Employer hereby makes application to Fidelity Security Life Insurance Company for Vision Care Benefits. The Employer agrees to maintain and furnish any records necessary to administer the plan, and to forward 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).

Broker Name (print): _____ Broker No.: _____

Address: _____ City: _____ State: _____ Zip: _____

Broker Signature: _____ Phone #: _____ Fax #: _____

Florida Licensed Agent (Print): _____ License I.D. No.: _____

Florida Licensed Agent Signature: _____

A-00725FL396

Internal Sales Rep: _____