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**VBA Vision  
 Group Application**  
 New Group  Changes

**Group Name:** \_\_\_\_\_ **Tax ID#:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Fax:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Person Completing Application:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Nature of Business:** \_\_\_\_\_

- We hereby apply for group vision care to be effective the 1<sup>st</sup> of the month beginning: \_\_\_\_\_  
 It is understood that: **Month / Year**
  - The group will not cover an employee who does not meet the group's eligibility guidelines.
  - All future eligible employees will be covered when they become eligible.
  - Coverage will terminate for an employee on the last day of the month in which his/her employment terminates.
- Eligibility: All full time W2 employees except: \_\_\_\_\_
- Number of Employees: \_\_\_\_\_
- Waiting Period: Present employees are eligible on the effective date of this contract. New employees will be eligible on the first day of the month following \_\_\_\_\_ months of full time employment.
- Dependent Coverage: If dependent coverage is being offered by the employer group, eligible dependents may include the covered participant's spouse, unmarried domestic partners\*, and dependent children who have not attained their 26th birthday. Dependent coverage is determined by the employer group. Please indicate below dependents that will be covered under this plan.
 

Spouse\*     Domestic Partner\*     Children who have not attained age 26

\*Evidence of domestic partnership MUST be provided at time of enrollment
- This application will become effective on the first (1<sup>st</sup>) day of \_\_\_\_\_ year \_\_\_\_\_ provided that all of the following has been completed prior to this effective date:
  - Application has been submitted to and accepted by Alera Group.
  - A check for the first month's coverage is included, payable to Alera Group.

**7. First month's remittance calculation:**

Select One	Plan Options	# Single Enrolls	Single Premium	Total Single Premiums	# Family Enrolls	Family Premium	Total Family Premiums	TOTAL PREMIUMS
(A)					(B)			(A + B)
	Option 1 – Plan 009		X \$5.76	=		X \$11.51	=	=
	Option 2 – Plan 2712		X \$7.85	=		X \$15.65	=	=
	Option 3 – Plan 2713		X \$8.70	=		X \$17.40	=	=
	Option 4 – Plan 4146		X \$10.44	=		X \$20.88	=	=
<b>All Rates Effective: 03/01/2020 – 02/29/2022</b>					Monthly Administrative Fee			+ 5.00
					Total First Month's Remittance			=

**Group Contact Signature:** \_\_\_\_\_

**Broker of Record Information: (If you do not have a broker of record please leave blank)**

**Agents Full Name:** \_\_\_\_\_ **Agency:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Fax:** \_\_\_\_\_