

# SFTLA EMPLOYER APPLICATION FOR VISION INSURANCE

Application is hereby made to VSP (the company) for group insurance based on the following statements.

**Please Use Ink or Type – An Incomplete Application Will Delay Processing**

<b>1. Name of Policyholder</b>	<b>Phone# (     )</b>
<b>2. Billing Address</b>	<b>City</b> <span style="float: right;"><b>State/Zip</b></span>
<b>3. Nature of Business or Industry</b>	
<b>4. Full-time employees must work at least _____ Hours per week (minimum 30)</b>	
<b>5. Total Number of Eligible Full-Time Employees _____</b> <b>Total Number of Eligible Dependents _____</b>	
<b>6. New employees become insured on 1st of the month following _____ days of full-time employment (minimum 30 days)</b>	
<b>7. PREMIUM to be contributed by employer: Employees <u>100%</u> Dependents _____%</b>	
<b>8. It is requested that the insurance be effective _____, subject to approval of this application and payment of the first monthly premium. Coverage for anyone not actively at work on the policy effective date shall be deferred until he or she returns to active work.</b>	
<b>9. Premiums shall be payable monthly.</b>	
<b>10. Person responsible for plan administration _____ Ph# _____</b>	

The requested insurance shall become effective if:

- a) this application is received and approved by Myers-Stevens- Mello & Co., Insurance Services and
- b) 100% of the eligible employees and their dependents are enrolled.

The policyholder agrees to pay the required premium as billed by Myers-Stevens-Mello & Co. Insurance Services and to enroll all employees and their dependents as they become eligible. Policyholder understands that minimum term of coverage for this plan is 24 months.

Signed \_\_\_\_\_ Title \_\_\_\_\_

Dated at \_\_\_\_\_ this \_\_\_\_\_, 200\_\_\_\_  
City/State Month/Day

Mail or Fax to Myers-Stevens-Mello & Co., Inc.  
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