

MWG Materials Only Vision Plan

GROUP APPLICATION

I. GROUP INFORMATION

Effective Date: _____ **Account Executive:** _____
Group Name: _____
Number of Eligible Employees: _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone Number: _____ **FaxNumber:** _____
Type of Business/SIC Code: _____
Group Contact: _____ **Title:** _____ **Phone:** _____
Billing Contact: _____ **Title:** _____ **Phone:** _____
Email Address: _____
Writing Agent: _____ **Phone:** _____

II. BILLING INFORMATION

(All correspondence should be sent to)

T. P. A. Billing: Morgan-White Administrators, Inc.

Billing Address: P. O. Drawer 14067 City: Jackson State: MS Zip: 39236 _____

Contact: Group Billing Phone: 1-800-800-1397 Fax: 1-601-956-3795

Initial Eligibility Provided Via: tape or diskette OR enrollment forms.

Ongoing Eligibility Provided Via: tape or diskette OR enrollment forms and change forms.

Dependent Coverage to age 19 or 23 if dependent is a full time student.

Previous Vision Plan, if any: _____

III. MONTHLY PREMIUMS:

Employee Only \$ _____ x appropriate number covered: _____ = \$ _____
Employee & One \$ _____ x appropriate number covered: _____ = \$ _____
Employee & Family \$ _____ x appropriate number covered: _____ = \$ _____

TOTAL \$ _____

IV. Vision Benefits Cards -Important

There is no policy or certificate issued for this program. Each person enrolling should be given a generic Vision Benefits Card that describes how to receive benefits and file claims.

Please indicate where MorganWhite Administrators should send the Vision benefits Card (we will include additional cards for new hires).

___ Send Benefits Cards to the employer for distribution

___ Send Benefits Cards to the agent for distribution

___ Do not send Benefits Cards, the agent distributed them during the enrollment

V. PLAN DETAILS

Funding: **Employer Paid** **Employee Paid**

Contract Dates: From: _____ To: _____

Frequency of Services: Lenses every 12 months; Frames every 24 months

Contact Lenses: Covered contact lens provided (in lieu of lenses and frame) every 12 Months. Non-Covered contact lens allowance of (**up to**) \$ 105.00 every 12 months for the retail cost of the lenses plus any dispensing and fitting fees.

Refractive Eye Surgery: Discount from Laser Vision Network of America
15% off "Standard" or "Usual and Customary Price" or "5% off of Promotional Price"

Co-payments: \$ 20.00 toward materials

Out-of Network reimbursements (Up To The Following Amounts):

\$ 40.00	Single Vision Lens	
\$ 60.00	Bifocal Lens	\$ 80.00 Trifocal Lens
\$ 80.00	Lenticular	\$ 45.00 Frames
\$105.00	Elective contacts	\$210.00 Necessary Contacts

VI. AGREEMENT

The undersigned group hereby agrees to vision care coverage through Spectera.

It is understood that:

- A. The group will make this plan available to all eligible employees and their dependents.
- B. All future employees will have this plan available to them when they become eligible.
- C. Coverage will terminate for an employee on the last day of the month of employee's termination.

Signature _____

Title _____ **Date** _____