

# MWG Vision

## GROUP APPLICATION

### I. GROUP INFORMATION

Effective Date:	Acct. Executive:		
Group Name:			
Number of Eligible Employees:	Employer Identification Number (Tax ID):		
Address:	City:	State:	Zip:
Phone:			
Type of Business/SIC Code:			
Group Contact:	Title:	Phone:	
Billing Contact:	Title:	Phone:	
Email Address:	Title:	Phone:	
Writing Agent:			Phone:

### II. BILLING INFORMATION

(All correspondence should be sent to)

**T.P.A. Billing:** Morgan-White Administrators, Inc.  
**Billing Address:** Post Office Drawer 14067, Jackson, MS 39236  
**Contact:** Group Billing      **Phone:** (800) 800-1397      **Fax:** (601) 956-3795

**Initial Eligibility Provided Via:**     tape / diskette    or     enrollment forms  
**Ongoing Eligibility Provided Via:**     tape / diskette    or     enrollment forms / change forms

**Dependent Coverage:**                    to age 19 or 23 if dependent is full time student  
**Previous Vision Plan,** if any:

### III. MONTHLY PREMIUMS

Employee Only	\$	x appropriate number covered:	=	\$
Employee & One	\$	x appropriate number covered:	=	\$
Employee & Spouse	\$	x appropriate number covered:	=	\$
Employee & Child(ren)	\$	x appropriate number covered:	=	\$
Employee & Family	\$	x appropriate number covered:	=	\$
<b>TOTAL:</b>				<b>\$</b>

### IV. VISION BENEFIT CARDS – Important

There is no policy or certificates 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 Morgan White 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 distribution**
- Do not send Benefit Cards, the agent distributed them during the enrollment**

**I. PLAN DETAILS**

Funding:  Employer Paid  Employee Paid

Contract Dates: From: To:

Frequency of Services: Exam every 12 months; 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: \$10.00 toward examination and \$20.00 toward materials (including Contact Lenses). Frames outside the covered Selection, you pay the wholesale cost of the frames minus a \$50.00 wholesale allowance.

Out-of-Network Reimbursements: (Up to The Following Amounts):

\$ 40.00 Examination	\$ 40.00 Single Vision Lens
\$ 60.00 Bifocal Lens	\$ 80.00 Trifocal Lens
\$ 80.00 Lenticular	\$ 50.00 Frames
\$105.00 Elective Contacts	\$210.00 Necessary Contacts

**VI. AGREEMENT**

**The undersigned group hereby agrees to vision care coverage through OptumHealth Vision.**

**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 the employee’s termination.**

\_\_\_\_\_  
Signature / Title

\_\_\_\_\_  
Date