MedBen health. benefits.

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☐ New Application
☐ Change Request
☐ Termination Notice

VISION EMPLOYEE APPLICATION

Vision Group/Account #_____

READ CAREFULLY AND COMPLETE IN INK TO PREVENT YOUR COVERAGE FROM BEING DELAYED.
COMPLETE ALL SECTIONS OF THE APPLICATION. SIGN AND DATE THE AGREEMENT AND AUTHORIZATION. IF YOU ARE APPLYING FOR SPOUSAL COVERAGE, HAVE YOUR SPOUSE SIGN AND DATE THE AGREEMENT AND AUTHORIZATION.

❶ Employee Information (Please print in ink):

Name _____ (Last / First / Middle Initial) Social Security Number _____

Home Address _____ (Street / City / State / Zip) Telephone _____

Employee Date of Birth
_____
Mo. Day Yr.

Sex
☐ Male
☐ Female

Marital Status
☐ Married
☐ Divorced
☐ Widowed
☐ Single
☐ Common Law *Complete Supplemental Information - Common Law Relationship*

Who Is to Be Insured
☐ Employee Only
☐ Employee and Spouse
☐ Employee and Children
☐ Employee, Spouse & Children

Date Hired
_____
Mo. Day Yr

COBRA Election Date
_____
Mo. Day Yr

Employed by _____ (Company Name / City, State of Employment / Group/Account Number)

Occupation _____ Hours Worked Weekly _____

❷ **Dependents to be covered**
(If any coverage is to be waived, complete the waiver area in Section 3):

Full Name	Date of Birth	Sex Male	Sex Female	S.S. Number (*Spouse Only*)						
Spouse:		☐	☐							
Other Dependent(s)				Natural Child	Adopted Child	Step-Child	Legal Guardian*	You and/or your Spouse provide over 50% of Support?	Resides with you? (Y/N)	Full-Time Student? (Y/N)**
		☐	☐	☐	☐	☐	☐			
		☐	☐	☐	☐	☐	☐			
		☐	☐	☐	☐	☐	☐			
		☐	☐	☐	☐	☐	☐			
		☐	☐	☐	☐	☐	☐			

**Please attach to this application copies of the court orders or legal documents creating this relationship. **If dependent is 19 or older, list the name of the dependent, the educational institution such child is currently attending and the number of credit hours for which currently enrolled.*

Spouse employed ☐ Yes ☐ No Employed By _____ Date of Marriage _____

Are you, your spouse or children covered or insured under any other dental or vision coverage? ☐ Yes ☐ No If "Yes", indicate who is covered under this other coverage, what type of coverage it is, and who the carrier is:

_____

Are any of the other Dependents listed on the prior page in the legal custody of another Person? ☐ Yes ☐ No If "Yes":

Dependent	Person with Legal Custody	Relationship to Dependent	Address of Custodian

❸

WAIVER OF COVERAGE

☐ I hereby waive THE FOLLOWING coverages. **(Check all that apply. Employee signature required below.)**

☐ All Vision Coverage ☐ Spouse Vision Coverage ☐ Dependent Child(ren) Vision Coverage

❹

Read this Agreement and Authorization Carefully

I hereby request coverage and authorize that any requested contribution for the insurance to which I may be entitled be deducted from my earnings. I am employed by the employer shown and am working at least the number of hours per week required by my Employer and shown on the Employer Application. I authorize (1) any physician, hospital, or other health practitioner or facility, (2) any insurance company or health care plan, (3) any state or federal agency providing health care benefits, and (4) any employer to provide Medical Benefits Mutual Life Insurance Co. or its legal representative any information in their possession which is relevant to this application for insurance regarding myself or my listed Dependent(s). This information will be used to determine the eligiblity for coverage and/or benefits for myself and my listed Dependent(s) and will be utilized by employees, agents and business associates of Medical Benefits Mutual Life Insurance Co. and its subsidiaries with responsibility for (1) reviewing applications and determining eligiblity for coverage, (2) payment of claims, and (3) any other health care operations. I hereby authorize and release any provider of health care services, claim administrators, insurers, reinsurers and others who have a legitimate need for such information for the purpose of review, investigation, or evaluation of a claim, health plan service, or health care operations to supply each other with information about the health status of, and health care services provided to, me and my listed Dependent(s). I understand that information disclosed by MedBen to any individuals listed in the preceding paragraph pursuant to this authorization may be subject to redisclosure by such individuals, and will no longer be protected by this authorization. This authorization is effective on the date signed and shall remain in effect until the date such coverage is terminated. (You or any individual authorized by law to act on your behalf have a right to receive a copy of this authorization.) A photographic copy of this authorization shall be as valid as the original. I understand that if I fail to provide this authorization, MedBen will be unable to process my application for coverage. I further understand that I have the right to revoke this authorization by submitting such revocation to MedBen's Chief Privacy Officer, Medical Benefits Mutual Life Insurance Co. at the address listed on this application. Such revocation will not be effective to the extent that action has been taken in reliance upon this authorization prior to MedBen's receipt of my revocation or to the extent that MedBen has the right to contest my coverage or a claim thereunder under applicable law. I hereby certify that I have personally answered all of the questions on this form and that my answers are true and complete to the best of my knowledge and belief. I have legal proof which I can furnish upon request of my relationship to any person listed as a Dependent above. I understand that any misstatements, or failure to report, may be used as a basis for recission or cancellation of the insurance for me and my Dependent(s), if any. I further understand that, should I drop any of the coverages listed on this application while still eligible, I may not be allowed to subsequently reapply for the same coverage.

WARNING: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is guilty of insurance or health care fraud under state and/or federal law.

Employee Signature _____ Date _____

Spouse Signature (if applying for coverage)_____ Date _____

I understand that if, upon receipt, the signature is more than 60 days old, a new application will be requested.