GroupVision SERVICE

UNITE HERE Local 25 & Hotel Association of Washington D.C. Health and Welfare Fund

Application for Renewal of Vision Care Benefits

Underwritten by Fidelity Security Life Insurance Company
Kansas, City, Missouri

We at GVS are very pleased to provide **UNITE HERE Local 25 & Hotel Association of Washington D.C. Health and Welfare Fund** and its members with vision benefits. We appreciate your business and look forward to a long-term relationship. Your signature indicates acceptance of the group renewal, rates and rate guarantee. Please return this renewal form to GVS by 5/1/18 via email to Craig Allebach at callebach@gvsmd.com

Renewal Date: 6/1/18

Group I.D.: 12030-6

Current Premiums:

Composite per hour	$.0672

Renewal Premiums:

Composite per hour	**$.0672**

Rate Guarantee: 24 months

Contribution: 100% Employer Paid

Commission: Net

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VC-83/VC87

This plan provides coverage for a vision examination, eyeglass lenses or contact lenses and frame. Vision benefits are available from an extensive national network of participating providers powered by Eye Med Vision Care. You can easily find a conveniently located provider near you. You have a choice of independent optometrists and ophthalmologists, as well as retail locations such as Lens Crafters, Sears Optical, Target Optical and JC Penney Optical and most Pearle Vision Centers. Members will receive additional savings from Network Providers for lens upgrades and additional pair purchases.

NETWORK PROVIDERS - By using a network provider, you minimize your out-of-pocket costs and receive the benefit of our paperless claims processing. Network Providers verify your eligibility and obtain all the necessary information to validate your level of coverage. You simply pay your copayment and any remaining balance for non-covered services or materials at the time of your appointment. In addition, Network Providers offer you discount pricing which is significantly below retail. You receive substantial savings of 15%-40% or more on most additional pair purchases, conventional contact lenses, lens treatments, specialized lenses and various accessory items. Out of Network Benefits** – If you choose to go to a non-network provider, you must pay the provider his or her full charges at the time of service. Members will be responsible for submitting a claim for reimbursement for the amount indicated in the member reimbursement schedule.

Benefits from a GVS Network Provider*		Copay	Out-of-Network Benefit Schedule **	
Vision Examination – includes dilation as indicated	Once Every 12 Months*	$ 0.00	Vision Examination	Up to $30.00
Eyeglass Lenses - single vision, bifocal, or trifocal in standard/basic plastic **w/Standard Scratch Resistance, Tints, Polycarbonate and Photochromic Lenses**	Once Every 12 Months*	$ 0.00	Lenses • Single Vision • Bifocal • Trifocal • Standard Scratch • Tints • Polycarbonate • Photochromic	 Up to $35.00 Up to $50.00 Up to $75.00 Up to $12.00 Up to $12.00 Up to $32.00 Up to $32.00
Frame – covered in full up to a **$ 150.00 retail value**. Members receive 20% off balance for selection costing more than the plan allowance **Glasses available through glasses.com**	Once Every 12 Months*	N/A	Frame	Up to $58.00
Contact Lenses - in lieu of spectacle lenses (does not include fitting and follow-up) • **Elective** – Disposable or Conventional, covered in full up to **$ 120.00** allowance. Conventional lenses: members receive 15% discount off balance over plan allowance. **Contacts available through contactsdirect**.com • **Medically Necessary** – Covered in full up to $250.00	Once Every 12 Months*	N/A	Elective Contact Lenses (in lieu of spectacle lenses) Medically Necessary Contact Lenses	Up to $105.00 Up to $200.00

*** Benefits are available 12 months from last date of service** *In-network services and materials may be subject to a copayment at the time of service. **Out-of-Network amounts are maximum reimbursable amounts paid to members after the claim is filed. **Co-pays do not apply to OON reimbursements.**

Additional Savings Program

Lens Options	Member Pricing	Other Options/Services	Member Pricing
Tint (solid & gradient) *	**Covered**	Other Lens Options and Services	20% off Retail
UV Coating	$15.00	Complete Pair Purchases ***	40% off Retail
Standard Scratch Resistance*	**Covered**	Conventional Contact Lenses	15% off Retail
Standard Polycarbonate Adult* **Standard Polycarbonate Children***	**Covered** **Covered**	Standard Contact Lens Fitting & Follow-up Premium Contact Lens Fitting & Follow-up	$40.00 10% discount
Standard Anti-Reflective	$45.00	**EPIC Hearing Savings Program (Discount Only)**	**Fixed Fee Schedule**
Standard Progressive Lens**	$65.00	Retinal Imaging	$39.00 max
Premium Progressive Lenses**	20% off Retail	**Photo chromatic Lenses***	**Covered**

Monthly Premium – Fully Insured	
Employer Paid Renewal Rate Guarantee 24 Months	
Composite per hour	**$.0672**

*Covered by plan benefit. ** Standard/Premium Progressive lenses are not covered benefits – however when upgrading in conjunction with your funded benefit the bifocal lens amount will be applied. Members are responsible for the lens copayment and any additional charges. (Bifocal co-pay + $65 + 80% of retail less $120. *** Discount applies on complete pair purchase once funded benefit is used.

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Kansas, City, Missouri

PROVIDE CURRENT GROUP INFORMATION, AS REFLECTED IN THE COMPANY'S RECORDS

Group Name: ______________________________
DBA, if applicable: ______________________________
Business Address: ______________________________
Primary Contact: ______________________________
Phone Number: ______________

YOU DO NOT NEED TO COMPLETE ALL SECTIONS BELOW. PLEASE CHECK AND COMPLETE SECTIONS ONLY IF CHANGES ARE REQUESTED IN THE AREA(S) IDENTIFIED.

YOU MUST ALSO SIGN AND DATE THE REVERSE SIDE WHERE INDICATED

☐ **NAME CHANGE (Same Tax ID Number):**______________________________

New Group Name: ______________________________
DBA, if applicable: ______________________________

☐ **CHANGE IN PRIMARY BUSINESS ADDRESS**

New Street Address: ______________________________
P.O. Box: ______________________________
City: ______________ State: ______________ Zip Code: ______________

☐ **CHANGE TO COVERAGE FOR DOMESTIC PARTNERS***

A. Are Domestic Partners to be covered under this Plan? ☐ Yes ☐ No

B. Same Sex*? ☐ Yes ☐ No Opposite Sex*? ☐ Yes ☐ No

** Except as required by state law.*

☐ **CHANGE TO DEPENDENT AGE COVERAGE**

Dependent Children to be covered to Age** ☐ 19 ☐ 21 ☐ 25 ☐ 26*** ☐ Other__________

Dependent Children to be covered if Full-Time Student** ☐ Yes ☐ No

If "Yes", Dependent Full-Time Student Covered to** ☐ 21 ☐ 25 ☐ 27 ☐ Other______________

***Unless state law has different requirements for Dependent Child status.*
**** Regardless of financial dependency, residency, student status, or marital status.*

☐ **NEW RATES, BENEFITS, NETWORK OR PLANS**

- ☐ A. New Rates: Please refer to the attached proposal page.
- ☐ B. New Benefits: Please refer to the attached proposal page.
- ☐ C. New Network: Please refer to the attached proposal page.
- ☐ D. New Plan: Please refer to the attached proposal page.

☐ **CHANGE IN GROUP SIZE - FLORIDA POLICYHOLDERS ONLY**

Original Number of full-time Employees: ____________________

New Number of full-time Employees: ____________________

The Group hereby makes application to Fidelity Security Life Insurance Company for renewal of the Vision Care Benefits. The Group agrees to maintain and furnish any records necessary to administer this plan and to forward premiums monthly.

The Group certifies that all of the information shown on the Application for renewal of Vision Care Benefits and any attachments are correct and complete as of the date this Application is signed. The Group understands that the Company intends to rely on this information in determining whether or not it can renew the Vision Care Benefits insurance. It is further understood and agreed that **NO INSURANCE WILL BECOME EFFECTIVE UNTIL APPROVED BY THE COMPANY;** and that no field representative of the Company has the authority to modify any conditions of the application or the Policy by making any promise or representation. It is understood that the insurance as to any Employee/Member will not become effective on the date insurance should otherwise be effective if he or she is not at work on such date performing all duties of his or her occupation and otherwise meets the requirements of the Company.

I hereby represent that I have reviewed the fraud warning notice (if applicable) on reverse side of this Application for the Group's state of domicile.

Renewal date: ____________________

*Authorized Signature ____________________

____________________ Date Signed ____________________

**Signature indicates acknowledgement of plan design, rates and effective dates for sold case implementation. The current guaranteed premium rate is subject to modification based upon any change in benefits, policyholder contributions; number of eligible employees, family size, information provided by the applicant on the application, governmental action or change in law or regulation, any of which, individually or in combination, may affect the Insurer's risk in underwriting this coverage.*

FRAUD WARNING NOTICE	
For residents of all states (except the following:)	Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
Alabama	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.
Arkansas, Louisiana Rhode Island West Virginia	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Colorado	It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
District of Columbia	Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the Applicant.
Florida	Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree.
Kentucky	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
Maine Tennessee Washington	It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
Maryland	Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Nebraska	Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a materially false or deceptive statement is guilty of insurance fraud.
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.
North Carolina	Any person with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which may subject the person to criminal and civil penalties.
Oklahoma	WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Oregon Texas Vermont	Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.
Pennsylvania	Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
Virginia	Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.