GroupVision SERVICE

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 **Warehouse Employees Union Local No. 730 Health and Welfare Trust Funds** 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 at the address indicated below.

Renewal Date: January 1, 2014

Group I.D.: 12030 - 1
Plan Code: 9756487

Current Rate(s)

Composite: $6.23

Renewal Rate(s)

Composite: 6.35

Rate Guarantee: 24 months

Plan Benefits from a Network Provider*			Member Reimbursement Out-of-network
Vision Examination with dilation as necessary	Once every 12 months	$ 10.00 Co-pay	Up to $ 30.00
Eyeglass Lenses - single vision, bifocal, or trifocal in standard/basic plastic.	Once every 12 months	$ 0.00 Co-pay	SV up to $35 BF up to $50 TF up to $75
Frame –covered in full up to a $120.00 retail value. Members receive 20% off balance for selection costing more than the plan allowance	Once every 24 months	N/A	Up to $50
Contact Lenses- in lieu of spectacle lenses (does not include fitting and follow-up)	Once every 12 months	N/A	
Elective – Disposable or Conventional, covered in full up to $105 allowance.			Up to $105.00
Non-Elective – Covered in full up to $250			Up to $200.00

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VC-83/VC-87

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.