# Inshore Benefits
## Employer Application — Vision

| Requested Effective Date: | FOR OFFICE USE ONLY Division #: | |
|---|---|---|

### 1. EMPLOYER INFORMATION

| | | |
|---|---|---|
| Preferred Company Name or DBA: | | |
| Company Tax ID: | SIC Code*: *(Required for dental coverage) | |
| Physical Address: | | |
| City: | State: | Zip Code: |
| Mailing Address (if different): | | |
| City: | State: | Zip Code: |
| Group Administrator: | Phone: | Email: |

### 2. GROUP ELIGIBILITY INFORMATION

| | | |
|---|---|---|
| Total # of **Employees**: | Total # of **Eligible Employees**: | Total # of **Enrolling Employees**: |

New hire waiting period is first of the month following: ☐ Date of Hire ☐ 30 Days ☐ 60 Days ☐ 90 Days

Is your group currently subject to: ☐ Federal COBRA (Employed 20+ eligible employees on at least 50% of its working days in the previous calendar year*)

☐ State COBRA (If so, please indicate state: _____ *)

*Check with your State Department of Labor for local eligibility rules or visit www.DOL.gov for more COBRA eligibility information.

### 3. INVOICE & PAYMENT PREFERENCES

Invoice Delivery via: ☐ Mail ☐ Email to _____ or ☐ Same email as Group Administrator in Section 1

Payment Mode: ☐ Check ☐ ACH Draft (**ACH Authorization Form** attached)

**Payment Terms**: Initial payment is required with application. Please make check payable to **Pathian Administrators**. This is a prepaid plan and monthly payments are due no later than the first day of the coverage month. Late fees will apply if not paid by the 15th of month due. If not paid by the last day of the month, group is subject to cancellation and subsequent reinstatement fee of $25.00.

**Monthly Administration Fee**: $15.00 administration fee will apply to invoice each month _____ Initial for acknowledgment of fees and terms

### 4. EMPLOYER SIGNATURE

**Participation Agreement:** We, the undersigned group, understand that we are applying for membership in the Inshore Benefits Trust ("Trust"). Ameritas, Delta Dental, Humana, and Vision Service Plan ("VSP") has issued a master policy to the Trust which provides dental and/or vision benefits to employer groups and their eligible employees and dependents. We certify that all information provided with respect to the company and its employees/members is accurate and complete. If not complete, Ameritas, Delta Dental, Humana, VSP and/or Pathian reserve the right to reject this application.

We, the undersigned group, understand that we have an obligation to ensure that all persons offered benefits meet eligibility requirements and that coverage is offered to every eligible person. We understand that we will be liable for any claims incurred during any period in which we do not meet the participation and eligibility maintenance requirements. We understand that VSP and/or Pathian will rely on the representations contained in this document and any others, such as applications, which we provide in determining whether they will accept us as an eligible group.

It is understood that coverage for any benefits shall not commence until a completed Employer Application has been approved by Ameritas, Delta Dental, Humana, VSP, and/or Pathian, its authorized agents, or representatives; the first month's premium for the purchased benefit plan(s) has been paid; all completed employee applications have been submitted; and notice of said approval has been transmitted in writing. We certify that the answers on any and all applications are true and understand that coverage may be rescinded should it be determined at a future date that there are misstatements in the applications.

Some of the contracts Ameritas, Delta Dental, Humana, and VSP hold with Warner Pacific Insurance Services ("Warner Pacific") provide for payment of incentives, compensation, excess surplus and bonuses ("compensation"). In the sole and exclusive discretion of Warner Pacific, such compensation may be retained by Warner Pacific or distributed to other parties. Such compensation will not be returned to you as the employer/plan sponsor. Any benefits claims submitted under your policy/certificate will be paid without regard to such compensation.

**Arbitration Agreement:** We understand that any dispute between us and Ameritas, Delta Dental, Humana, VSP, Warner Pacific and/or Pathian must be resolved through binding arbitration if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court and not by lawsuit or court process, except as California provides for judicial review of arbitration proceedings.

I certify that all of the information provided in this document is accurate to the best of my knowledge as of the date signed.

**I also understand that the current rates are guaranteed from January through December. These plans renew every January 1st regardless of the original effective date. A $15.00 administration fee will apply to invoice each month.**

| | |
|---|---|
| **Signature of Company Officer:** | **Title:** |
| **Name (print):** | **Date:** |

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### 5. VISION COVERAGE SELECTION

### EMPLOYER SPONSORED VISION SERVICE PLAN

Rates Effective January 1, 2020 through December 31, 2020

| Choose ONE Plan | Plan Name | Employee Only | EE + 1 or Employee + Children | EE + Family |
|---|---|---|---|---|
| ☐ Plan # 0080 | Choice A $0 12/24/24 | $7.93 | $13.03 | $20.97 |
| ☐ Plan # 0081 | Choice B $0 12/12/24 | $11.12 | $16.92 | $27.28 |
| ☐ Plan # 0066 | Signature A $25 12/24/24 | $8.68 | $13.18 | $21.28 |
| ☐ Plan # 0002 | Signature B $25 12/12/24 | $10.86 | $16.52 | $26.61 |
| ☐ Plan # 0069 | Signature C $25 12/12/12 | $13.27 | $20.18 | $32.50 |
| ☐ Plan # 0067 | Signature A $10 12/24/24 | $11.03 | $16.55 | $26.67 |
| ☐ Plan # 0001 | Signature B $10 12/12/24 | $13.75 | $20.68 | $33.32 |
| ☐ Plan # 0068 | Signature C $10 12/12/12 | $16.79 | $25.24 | $40.65 |

**Employer Sponsored VSP Participation Requirements**:
Minimum of 3 enrolled employees at all times.

**The employer must choose one of the following participation options**:

- ☐ **Option 1** — VSP participation and contribution matches employer-sponsored medical plan participation exactly
- ☐ **Option 2** — VSP participation and contribution matches employer-sponsored dental plan participation exactly
- ☐ **Option 3** — VSP participation is 100% employer paid, and all eligible employees and all eligible dependents are enrolled
- ☐ **Option 4** — VSP participation is 100% employer paid and all eligible employees and no dependents are enrolled

### VOLUNTARY VISION SERVICE PLAN

Rates Effective January 1, 2020 through December 31, 2020

| Choose ONE Plan | Plan Name | Employee Only | EE + 1 or Employee + Children | EE + Family |
|---|---|---|---|---|
| ☐ Plan # 0009 | Choice A $15/$30 12/24/24 | $8.55 | $13.34 | $20.87 |
| ☐ Plan # 0010 | Choice B $15/$30 12/12/24 | $11.36 | $17.91 | $28.28 |
| ☐ Plan # 0025 | Signature C $15/$30 12/12/12 | $17.32 | $27.24 | $42.94 |

**Voluntary VSP Participation Requirements**: Minimum of 1 enrolled employee at all times. Employer contribution can be 0% to 100%.

All VSP plans are only available to groups headquartered in one of the following states: CA, CO, GA, IA, IL, IN, KS, MI, MN, MO, NC, NJ, NV, OH, OK, SC, TN, TX, and WV. Employees can live in any state, excluding FL.

**ALL VISION ELIGIBILITY:** Eligible employees must enroll at initial enrollment, or within 30 days of a Qualifying Event. Eligible employees declining dependent coverage **cannot enroll their dependents at a later time** unless the dependents show proof of loss of prior coverage. An eligible dependent is an employee's spouse/domestic partner and any child of the enrolled applicant or spouse/domestic partner who is under age 26. It is the employee's responsibility to inform the group administrator of any change in status of his/her dependents. Dependent children may remain on this plan to age 26. Florida residents do not qualify.

| 7. AGENT INFORMATION | | |
|---|---|---|
| Agent Name: | | Inshore Agent ID #: |
| License #: | State Issued: | Expiration (MM/YY): |
| Mailing Address: | | |
| City: | State: | Zip Code: |
| Agency Name: | | |
| Agency Mailing Address (if different): | | |
| City: | State: | Zip Code: |
| Email: | Phone: | Fax: |
| **Agent's Certification**: I hereby certify that I am not aware of any information that has been withheld from this application by the client and which may have bearing on this risk. I hereby certify that I have advised the client not to terminate any existing coverage until they have received written notification from Warner Pacific Insurance Services and/or Pathian that the coverage being requested by this application is accepted. Upon first submission, the agent or agency must provide copy of current Producer License and a completed W-9. | | |
| **Agent Signature:** | | **Date:** |
| **Agent Name (Print):** | | |