VBA Vision
Group Application
☐ New Group ☐ Changes

Capital Region Benefits, Inc
3819 Market Street ▲ Camp Hill, PA 17011
(717) 975-9300 ▲ (717) 975-9303 Fax
www.capitalregionbenefits.com
admin1@crbenefits.net

Group Name: _____ **Tax ID#:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____ **Phone:** _____

Fax: _____ **Email:** _____

Person Completing Application: _____ **Title:** _____

Nature of Business: _____

1. We hereby apply for group vision care to be effective the 1st of the month beginning: _____
   Month / Year
   It is understood that:
   A. The group will not cover an employee who does not meet the group's eligibility guidelines.
   B. All future eligible employees will be covered when they become eligible.
   C. Coverage will terminate for an employee on the last day of the month in which his/her employment terminates.

2. Eligibility: All full time W2 employees except: _____

3. Number of Employees: _____

4. Waiting Period: Present employees are eligible on the effective date of this contract. New employees will be eligible on the first day of the month following _____months of full time employment.

5. Dependent Coverage: If dependent coverage is being offered by the employer group, eligible dependents may include the covered participant's spouse, unmarried domestic partners*, and dependent children who have not attained their 26th birthday. Dependent coverage is determined by the employer group. Please indicate below dependents that will be covered under this plan.
   ❑ Spouse* ❑ Domestic Partner* ☐ Children who have not attained age 26
   *Evidence of domestic partnership MUST be provided at time of enrollment

6. This application will become effective on the first (1st) day of _____year_____ provided that all of the following has been completed prior to this effective date:
   A. Application has been submitted to and accepted by Capital Region Benefits, Inc.
   B. A check for the first month's coverage is included, payable to Capital Region Benefits, Inc.

7. **First month's remittance calculation:**

Select One	Plan Options	# Single Enrolls	Single Premium	Total Single Premiums	# Family Enrolls	Family Premium	Total Family Premiums	TOTAL PREMIUMS
				(A)			(B)	(A + B)
	Option 1 – Plan 009		X $5.76	=		X $11.51	=	=
	Option 2 – Plan 2712		X $7.85	=		X $15.65	=	=
	Option 3 – Plan 2713		X $8.70	=		X $17.40	=	=
	Option 4 – Plan 4146		X $10.44	=		X $20.88	=	=
All Rates Effective: 03/01/2017 – 02/29/2020							Monthly Administrative Fee	+ 5.00
							Total First Month's Remittance	=

Group Contact Signature: _____

Broker of Record Information: (If you do not have a broker of record please leave blank)

Agents Full Name: _____ **Agency:** _____

Address: _____ **Phone:** _____

Email: _____ **Fax:** _____