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 Application for VBA Vision ☐ New ☐ Change

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 subscriber/member group will not cover an employee/member who does not meet the subscriber/member group's eligibility guidelines.
   B. All future eligible employees/members will be covered when they become eligible.
   C. Coverage will terminate for an employee/member on the last day of the month in which his/her employment terminates.
   D. The criteria listed in attachment(s) will control coverage for benefits.

2. Eligibility: All full time W2 employees/members except: ____

3. Number of Employees: ____________

4. Waiting Period: Present employees/members are eligible on the effective date of this contract. New employees/members 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.*Evidence of domestic partnership MUST be provided at time of enrollment
   Please indicate below dependents that will be covered under this plan
   ❑ Spouse* ❑ Domestic Partner* ☐ Children who have not attained age 26

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: 3/1/17 – 2/29/20					Monthly Administrative Fee			+ 5.00
					Total First Month's Remittance			=

Group Contact Signature: ____

Broker of Record Agent: ______________________ **Agency:** ______________________

Address: ____

Phone: ______________________ **Fax:** ______________________

Email: ______________________