

CoPower **SELECT** Program VSP

Group Information - CoPower communication is by electronic mail.

Company Name:		DBA:	
Street Address:			
City:	State:	Zip:	
Billing Address (if different):			
City:	State:	Zip:	
Contact Name:		Title:	
E-mail:	Phone:	Fax:	
If you wish to opt out of E-mail communication, check this box <input type="checkbox"/>		SIC Code (required):	
Type of Business:	Tax ID #:	Date Business Established:	
Employer is a: <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Public Agency <input type="checkbox"/> Other (Please Explain): _____		Requested Effective Date:	HR360 Enrollment <input type="checkbox"/> Yes <input type="checkbox"/> No (Free Online HR Support):

Vision Service Plan (2-1000)

Total # of Employees: _____	Total # of Eligible Employees: _____	Total # of Enrolling Employees: _____
Employer Contribution	Employee: _____ (100% for all plans except the voluntary plans)	Dependent: _____ (minimum 0%)
Prior Carrier: <input type="checkbox"/> None	<input type="checkbox"/> Choice Plan A \$20	<input type="checkbox"/> Choice Plan B \$10/\$25 Vol
	<input type="checkbox"/> Choice Plan B \$25	<input type="checkbox"/> Choice Plan C \$25
	<input type="checkbox"/> Choice Plan B \$25 (\$130)	<input type="checkbox"/> Choice Plan C \$25 (\$130)
	<input type="checkbox"/> Choice Plan B \$20/\$20 Vol	<input type="checkbox"/> Choice Plan C \$25 Vol
Cancel Date:	<input type="checkbox"/> Choice Plan C \$20/\$20 Vol	<input type="checkbox"/> Choice Plan C \$10/\$25 Vol
		<input type="checkbox"/> Signature Plan B \$25

Group Eligibility Information / Carve-Out / COBRA

<p>Is the new hire waiting period waived for initial enrollments? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Eligibility begins on the first of the month following: <input type="checkbox"/> Date of Hire <input type="checkbox"/> 1 Mo. <input type="checkbox"/> 2 Mo. <input type="checkbox"/> 3 Mo. <input type="checkbox"/> Days: _____ <input type="checkbox"/> Other: _____</p>	<p>Is this group a class carve-out? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, state the class of employees to be covered: _____</p> <p>Is your group currently subject to: <input type="checkbox"/> Cal-COBRA <input type="checkbox"/> Fed-COBRA</p> <p>Cal-COBRA: Employed 2-19 eligible employees on at least 50% of its working days in the previous calendar year*</p> <p>Fed-COBRA: Employed 20+ eligible employees on at least 50% of its working days in the previous calendar year*</p> <p>*Visit www.dol.gov for more COBRA eligibility information.</p>
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Administrative Fee Policy - Charged monthly

\$15 - VSP (2-4 Groups receive a 1 year discounted rate of \$10)
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Payment/Invoice - CoPower communication is by electronic mail

Invoices If you wish to opt out of E-mail invoices, check this box

Contact Name _____ Email address _____

The above information will be used to authenticate access to the invoice. You must notify CoPower if this contact or e-mail address changes.

Initial Payment Do you wish to have your initial payment debited from your company account?

Yes Please complete the bank information below, enter the premium amount and attach a copy of a voided check.

No Please submit a company check made payable to CoPower.

Ongoing Payment Do you wish to have your monthly invoice amount automatically debited from your company account?

Yes Please complete the bank information below and attach a copy of a voided check. *(Allow up to one billing cycle to process your request. You must continue to submit your payment until your invoice indicates that the amount due will be debited from your account.)*

No

Bank Account Information *(must be a Checking Account)*

Account Holder's Name (if different from above): _____

Name of Bank: _____

Bank Address: _____

Bank Routing Number: _____

Account Number: _____

Premium Amount - Number (e.g. \$50): _____

\$

Premium Amount - Written (e.g. fifty dollars) _____

dollars

I hereby authorize CoPower to initiate debits from the account identified above. I understand it remains in effect until I give written notice to CoPower, which I must do by the 25th of the month prior to the month coverage. If I want to change the banking information that CoPower debits, I will submit a new Direct Debit Authorization form by the 25th of the month prior to the month of coverage. In the event a debit is made to my account in error, I authorize CoPower to make a correcting entry to my account. CoPower will notify me of payments returned for insufficient funds or close accounts, and repayment instructions.

Employer Signature

My Signature on this document certifies that all of the information contained in this application is true and correct to the best of my knowledge. I confirm that all enrollees are eligible employees, COBRA participants, and/or their dependents. In addition, my group complies with all the rules and regulations as set forth by the applicable carrier(s).

Signature of Company Officer: _____

Date: _____

Name (print): _____

Title (print): _____

Producer Statement (Must be completed for commissions. Producers (agent or agency) must have a signed Producer Agreement with CoPower.)

Producer's Signature:			Producer's Signature:		
Producer's Name (print):			Producer's Name (print):		
Federal Tax ID or SSN:			Federal Tax ID or SSN:		
Company Name:			Company Name:		
Address:			Address:		
City:			City:		
State:	Zip:	Date:	State:	Zip:	Date:
Telephone:		Fax:	Telephone:		Fax:
E-mail:			E-mail:		
Make commissions payable to: <input type="checkbox"/> Producer <input type="checkbox"/> Agency			Make commissions payable to: <input type="checkbox"/> Producer <input type="checkbox"/> Agency		
Multiple producer split: <input type="checkbox"/> Yes <input type="checkbox"/> No		Percentage of split: %	Multiple producer split: <input type="checkbox"/> Yes <input type="checkbox"/> No		Percentage of split: %