



## MASTER APPLICATION

APPLICATION is made to The First Rehabilitation Life Insurance Company of America for a policy of group Vision Expense Benefits Insurance (which a copy of this application is attached to and made part of), based on the following: (Please print. Please answer all questions.)

- 1) Company Name (Policyholder) \_\_\_\_\_  
Correspondent \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Telephone Number (\_\_\_\_) \_\_\_\_\_
- 2) List the names and addresses of all subsidiaries or affiliated companies whose employees will be covered.  
\_\_\_\_\_  
\_\_\_\_\_
- 3) Nature of business \_\_\_\_\_  
(if more space is needed, attach an extra sheet.)
- 4) Total number of full-time employees: \_\_\_\_\_  
(A full time employee is one who works a minimum of 30 hours per week on a permanent, full-time basis at the employer's usual place of business or at a location to which the employer's business requires the employee to travel.)
- 5) Total number of eligible employees: \_\_\_\_\_  
Full-time employees who have completed one month's employment, and their eligible dependents, are eligible immediately. Other full-time employees and their eligible dependents shall be eligible on the premium due date next following completion of the following waiting period \_\_\_\_\_
- 6) Total number of employees to be insured: \_\_\_\_\_
- 7) Class(es) of employees eligible (describe): \_\_\_\_\_  
\_\_\_\_\_
- 8) Class(es) of employees ineligible (describe): \_\_\_\_\_  
\_\_\_\_\_
- 9) Has the group ever had vision coverage? \_\_\_\_ If yes, name of carrier? \_\_\_\_\_  
Reason for termination? \_\_\_\_\_

- 10) Has the group ever had coverage with First Rehabilitation? \_\_\_\_\_  
 If yes, what type? \_\_\_\_\_ For how long? \_\_\_\_\_  
 Reason for termination? \_\_\_\_\_
- 11) This program is on a (check one) contributory \_\_\_\_ ; or non-contributory \_\_\_\_ basis. (If this is a contributory program, at least 75% participation must be maintained.)  
 Check one \_\_\_\_ employee-only coverage; or \_\_\_\_ employee and dependent coverage.
- 12) Premium is paid monthly on the first day of each calendar month. One month's deposit premium of \$ \_\_\_\_\_ must accompany this application.
- 13) This policy is effective on \_\_\_\_\_ at 12:01 A.M. local time at the place at which this policy is delivered.
- 14) Schedule of benefits: Check applicable item(s):  
 Plan A `` Plan B `` Plan C `` Plan D `` Plan E `` Plan Z ``
- 15) Rates will be \_\_\_\_\_ per single employee monthly; \_\_\_\_\_ per family unit monthly (including the employee).

No one except the President, a Vice President or the Secretary of The First Rehabilitation Life Insurance Company of America may make or modify any contract on behalf of The First Rehabilitation Life Insurance Company of America, and no waiver is valid unless in writing and signed by one of these officers.

All statements made by the Applicant are true and correct to the best of the Applicant's knowledge and belief.

***NOTICE:*** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Dated \_\_\_\_\_ Signature of Employer \_\_\_\_\_  
 Name \_\_\_\_\_  
 Title \_\_\_\_\_

Dated \_\_\_\_\_ Signature of Agent \_\_\_\_\_  
 Agent's Address \_\_\_\_\_  
 \_\_\_\_\_

The First Rehabilitation Life Insurance Company of America