

Vision Sold Case Form

GROUP PROFILE - Please print or type.

Legal Name of Policyholder: _____

Requested Effective Date of Coverage: _____ IRS Reporting Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Mailing Address (if different than above): _____

City: _____ State: _____ Zip Code: _____ County: _____

Phone Number: (____) _____ - _____ Nature of Business: _____ SIC: _____

Business Type: Association Sole Proprietorship Partnership Corporation Other _____

Other Locations or Affiliated Companies/Subsidiaries to be Included: Yes No *If Yes, Please List Names(s) and Location(s)*

Group Contact: _____ Title: _____

Phone Number: (____) _____ - _____ Fax Number: (____) _____ - _____ E-Mail _____

ELIGIBILITY

Number of Eligible Employees: _____ Number of Enrolled Employees: _____

Are Dependents Covered: Yes No Number of Enrolled Dependents: _____

Dependent Coverage Age Limit: To age 19, student to age 23 Other: _____

Domestic Partner Coverage: Yes No

Type of Funding:

Non-Contributory - (100% Employer Paid) - 100% Employee Participation

Contributory - (50% Employee Paid) - 75% Employee Participation

Employer's Contribution for Employees: _____ % or \$ _____

Employer's Contribution for Dependents: _____ % or \$ _____

Voluntary Group - (100% Employee Paid) - 20% Employee Participation

_____ % Participation

Eligibility Waiting Period:

New Employees: First day of month coinciding with or following _____ days of employment.

Other _____

Present Employees: All are eligible immediately, regardless of length of service.

Only those who have satisfied the waiting period above are eligible. (Please provide hire dates.)

Eligibility Hours Worked Per Week:

Full time employees working 30 or more hours Other _____

(continued on back)



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