Supplemental Questionnaire for Group Vision Preferred Provider Organization (PPO) Policy

Employer Contribution:

☐ None - Coverage is voluntary
☐ Fully Insured
☐ Employer Contribution *(Indicate amount below)*
☐ ASO

Employer Contribution for Employee: $_____or_____% per month

Employer Contribution for Dependents: $_____or_____% per month

Eligibility Period:

☐ Coverage begins _____ days from the first day of Actively at Work
☐ Coverage is effective on the first of the month following _____ days of employment.
☐ Coverage is effective on the first of the month following _____
☐ Coverage is effective on the date of hire.

Remarks/Additional Information:

Broker Information:

Producer Name:			Agency Name:
Address:			City:
State:	Zip:	Phone:	Email:

Account Manager Name:			Agency Name:
Address:			City:
State:	Zip:	Phone:	Email:

General Agency Information (If Applicable):			
Broker Name:			Agency Name:
Address:			City:
State:	Zip:	Phone:	Email:

Commission Payable to:	
☐ Broker	☐ Agency
Tax ID # for Commissions:	