UA LOCAL 136
PLUMBERS & STEAMFITTERS

2024 BENEFITS GUIDE

Inside the Guide

This brochure summarizes the benefit plans that are available to The Equity eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.

Local 136
2024 Vision/Dental Open Enrollment Announcement

- This insurance is Voluntary- which means you pay the full premium
- You must pay the quarterly premiums before your dues will be accepted. Be sure to review the rates. Do not accept the coverage if you cannot pay the premiums!
- You cannot cancel the coverage unless you have a qualifying event (coverage gained elsewhere)
- You must re-enroll to keep your current coverage
- Be sure to return the respective enrollment forms AND the signed contract
- We cannot accept late forms. Be sure to submit your forms AND contract NO LATER than November 20, 2023!
- Print the forms AND contract from the website (www.ualocal136.org-ResourcesTab) complete, sign and return them to the union hall by mail, fax, or email

2300 St. Joseph Industrial Park Dr., Evansville, IN 47720
Fax: 812-423-5517
Email: kathy@ualocal136.org

USI Contacts:	Phone:	Email:
Brandon Adamson	812-208-6713	Brandon.Adamson@usi.com
Sammie Danz	317-833-2002	Sammie.Danz@USI.com

Carrier Contacts:	Phone:	Website:
Delta Dental	800-524-0149	www.deltadental.com
Anthem Blue Cross and Blue Shield	866-723-0515	www.anthem.com

Plumbers & Steamfitters Local 136

Voluntary Dental & Vision Insurance Benefit Plan

Effective January 1, 2024

Dental Plan Coverage

www.deltadental.com

- 100% Preventative Care U&C
- 80% Basic Services
- 50% Major Services
- No Deductibles
- $1000 Annual Max per person
- $1000 Orthodontia Lifetime Maximum

Vision Plan Coverage

www.anthem.com

* $10 Routine Exam Co-Pay
* $25 Materials Co-Pay
* Routine Exams Every 12 Months
* Lenses Every 12 Months
* Frames Every 24 Months

NO SAFTEY GLASSES COVERAGE AVAILABLE

Safety Glasses will be available under a discount plan

Contact Local 136 for details

Voluntary Plan Participants	Voluntary Dental Monthly Rates	Voluntary Vision Monthly Rates
Member Only	$42.19	$8.09
Member + Spouse	$90.23	$16.18
Member + Children	$100.23	$17.32
Member + Family	$151.34	$27.65

DELTA DENTAL

Anthem

DELTA DENTAL®

Delta Dental PPO™ (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 1236-0001, 0099
Plumbers & Steamfitters Local 136

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the Dentist's network participation.*

Control Plan – Delta Dental of Indiana

Benefit Year – January 1 through December 31

Covered Services –

	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services – fillings and crown repair	80%	80%	80%
Endodontic Services – root canals	80%	80%	80%
Surgical Periodontic Services – surgical services to treat gum disease	80%	80%	80%
Extractions – removal of teeth	80%	80%	80%
Major Restorative Services – crowns	80%	80%	80%
Major Services			
Emergency Palliative Treatment – to temporarily relieve pain	50%	50%	50%
Non-Surgical Periodontic Services – non-surgical services to treat gum disease	50%	50%	50%
Other Oral Surgery – dental surgery other than extractions	50%	50%	50%
Major Restorative Services - inlays and veneers	50%	50%	50%
Other Basic Services – misc. services	50%	50%	50%
Relines and Repairs – to prosthetic appliances	50%	50%	50%
Prosthodontic Services – bridges, implants, dentures, and crowns over implants	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	through age 25 and under	through age 25 and under	through age 25 and under

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her Dentist about treatment.
- Fluoride treatments are payable twice per calendar year with no age limit.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) or a panorex are payable once in any four-year period.

- Sealants are payable once per tooth per five-year period for first and second permanent molars for people age 14 and under. The surface must be free from decay and restorations.
- Crowns, onlays, and substructures are payable once per tooth per seven-year period. Veneers are payable on incisors, cuspids, and bicuspids once per tooth per seven-year period for people age 16 and older when necessary due to fracture or decay.
- Composite resin (white) restorations are payable on posterior teeth.
- Metallic inlays are Covered Services.
- Porcelain and resin facings on crowns are Covered Services on posterior teeth.
- Full and partial dentures are payable once in any seven-year period. Reline and rebase of dentures and tissue conditioning are payable once in any four-year period.
- Bridges are payable once in any seven-year period.
- Implants are payable once per tooth in any seven-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any seven-year period. Services related to crowns over implants are Covered Services.
- People with special health care needs may be eligible for additional services including exams, hygiene visits, dental case management, and sedation/anesthesia. Special health care needs include any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, healthcare intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of Dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our website or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – $1,000 per Member total per Benefit Year on all services except orthodontic services. $1,000 per Member total per lifetime on orthodontic services.

Payment for Orthodontic Service – When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 50% of the per month fee charged by your Dentist based upon the agreed upon payment plan provided by Delta Dental to your Dentist.

Deductible – None.

Waiting Period – Enrollees who are eligible for dental benefits are covered on the date of hire.

Eligible People – All full-time employees of the Contractor working at least 30 hours per week who choose the dental plan (0001) and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees (0099).

Also eligible are your Spouse and your Children to the end of the month in which they turn 26, including your Children who are married, who no longer live with you, who are not your dependents for Federal income tax purposes, and/or who are not permanently disabled.

Enrollees and dependents choosing this plan are required to remain enrolled for a minimum of 12 months. Should an Enrollee or Dependent choose to drop coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may only enroll if the Enrollee is enrolled (except under COBRA) and must be enrolled in the same plan as the Enrollee. An election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

Coordination of Benefits –If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled together on one application or separately on individual applications, but not both. Your Dependent Children may only be enrolled on one application. Delta Dental will not coordinate Benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Enrollees under This Plan.

Benefits will cease on the date of termination.

Blue View Vision℠
FS.B.10.25.130.150
Plumbers and Steamfitters Local 136 Effective 1/1/2024

Anthem

Welcome to your Blue View Vision plan!

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice doctors, local optical stores, and national retail stores including LensCrafters®, Target Optical®, and most Pearle Vision® locations. You may also use your in-network benefits to order eyewear online at Glasses.com and ContactsDirect.com. To locate a participating network eye care doctor or location, log in at **anthem.com**, or from the home page menu under Care, select **Find a Doctor**. You may also call member services for assistance at **1-866-723-0515**.

Out-of-Network – If you choose to, you may instead receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance.

YOUR BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Routine Eye Exam			
A comprehensive eye examination	$10 Copay	Reimbursed Up To $35	Once every calendar year
Eyeglass Frames			
One pair of eyeglass frames	$130 Allowance, then 20% off any remaining balance	Reimbursed Up To $45	Once every other calendar year
Eyeglass Lenses *(instead of contact lenses)*			
One pair of standard plastic prescription lenses			
○ Single vision lenses	$25 Copay	Reimbursed up to $25	Once every calendar year
○ Bifocal lenses	$25 Copay	Reimbursed up to $40	
○ Trifocal lenses	$25 Copay	Reimbursed up to $55	
○ Lenticular lenses	$25 Copay	Reimbursed up to $80	
Eyeglass Lens Enhancements *When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost*			
○ Transitions Lenses (for a child under age 19)	$0 Copay	No allowance when obtained out-of-network	Same as covered eyeglass lenses
○ Standard polycarbonate (for a child under age 19)	$0 Copay		
○ Factory Scratch Coating	$0 Copay		
Contact Lenses *(instead of eyeglass lenses)* *Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.*			
○ Elective conventional (non-disposable) OR	$150 Allowance, then 15% off any remaining balance	Reimbursed up to $105	Once every calendar year
○ Elective disposable OR	$150 Allowance *(no additional discount)*	Reimbursed up to $105	
○ Non-elective (medically necessary)	Covered in full	Reimbursed up to $210	

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview. This benefit overview is only one piece of your entire enrollment package.

EXCLUSIONS & LIMITATIONS (not a comprehensive list – please refer to the member Certificate of Coverage for a complete list)

Combined Offers. Not to be combined with any offer, coupon, or in-store advertisement.
Excess Amounts. Amounts in excess of covered vision expense.
Sunglasses. Plano sunglasses and accompanying frames.
Safety Glasses. Safety glasses and accompanying frames.
Not Specifically Listed. Services not specifically listed in this plan as covered services.
Lost or Broken Lenses or Frames. Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.
Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.
Orthoptics. Orthoptics or vision training and any associated supplemental testing

Contract code: 57YC

OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY		In-Network Member Cost (after any applicable copay)
Retinal Imaging – at member's option, can be performed a time of eye exam		Not more than $39

Eyeglass lens upgrades
When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.
	○ Transitions lenses (Adults)
	○ Standard Polycarbonate (Adults)
	○ Tint (Solid and Gradient)
	○ UV Coating
	○ Progressive Lenses[1]
	  ○ Standard
	  ○ Premium Tier 1
	  ○ Premium Tier 2
	  ○ Premium Tier 3
	○ Anti-Reflective Coating[2]
	  ○ Standard
	  ○ Premium Tier 1
	  ○ Premium Tier 2
	○ Other Add-ons
		$75
		$0
		$15
		$15
		
		$65
		$85
		$95
		$110
		
		$45
		$57
		$68
		20% off retail price

Additional Pairs of Eyeglasses Anytime from any Blue View Vision network provider	○ Complete Pair ○ Eyeglass materials purchased separately	40% off retail price 20% off retail price
Eyewear Accessories	Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail
Contact lens fit and follow-up A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.	○ Standard contact lens fitting[3] ○ Premium contact lens fitting[4]	Up to $55 10% off retail price
Conventional Contact Lenses	○ Discount applies to materials only	15% off retail price

[1] Please ask your provider for his/her recommendation as well as the available progressive brands by tier.

[2] Please ask your provider for his/her recommendation as well as the available anti-reflective brands by tier.

[3] Standard fitting includes spherical clear lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

[4] Premium fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

Cannot be combined with any other offer. Discounts are subject to change without notice. Discounts are not covered benefits under your vision plan and will not be listed in your certificate of coverage. Discounts will be offered from in-network providers except where State law prevents discounting of products and services that are not covered benefits under this plan. Discounts on frames will not apply if the manufacturer has imposed a no discount on sales at retail and independent provider locations.

Some of our in-network providers include:

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL

Online stores:

GLASSES.COM glasses.com | contactsdirect contactsdirect.com | 1800contacts 1800contacts.com | LENSCRAFTERS lenscrafters.com | OPTICAL targetoptical.com | Ray-Ban ray-ban.com/insurance

ADDITIONAL SAVINGS AVAILABLE THROUGH ANTHEM'S SPECIAL OFFERS PROGRAM

Savings on items like additional eyewear after your benefits have been used, non-prescription sunglasses, hearing aids and even LASIK laser vision correction surgery are available through a variety of vendors. Just log in at **anthem.com**, select discounts, then Vision, Hearing & Dental.

* Discounts cannot be used in conjunction with your covered benefits.

OUT-OF-NETWORK

If you choose to receive covered services or purchase covered eyewear from an out-of-network provider, network discounts will not apply and you will be responsible for payment of services and/or eyewear materials at the time of service. Please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. To download a claim form, log in at **anthem.com**, or from the home page menu under Support select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at 1-866-723-0515 .to request a claim form.

TO FAX: 866-293-7373
TO EMAIL: ooneclaims@eyewearspecialoffers.com
TO MAIL: Blue View Vision
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

Plumbers & Steamfitters Local Union No. 136
Voluntary Dental and Vision Plan Contract

Voluntary Dental and Vision Plan Establishment – The Plumbers & Steamfitters Local Union No. 136 Membership unanimously voted to establish a Voluntary Dental and Vision Plan at their Union Meetings on September 30, 2008 (Bloomington, IN) and October 1, 2008 (Evansville, IN).

Coverage Availability – Coverage through Plumbers & Steamfitters Local Union No. 136's Voluntary Dental and Vision Plan is available ***only*** to a Member in good standing of Local Union No. 136.

Enrollment – Open enrollment will occur on a yearly basis in November for coverage the following year. An enrollment form must be completed and signed by the Member and will commit the Member to one calendar year, or 12 (twelve) consecutive months of premium payments and coverage.

Payment – Invoices will be mailed to the enrolled Member on a quarterly basis, the 1st week of the month prior to the start of each quarter (December, March, June and September) and are due on or before the 17th of the same month as the billing. The invoiced amount will be determined by the option that the Member has chosen on the Enrollment Form. **Payment of the quarterly invoice shall be made payable to: Plumbers & Steamfitters Local 136 General Fund and submitted to Local 136, 2300 St. Joseph Industrial Park Drive, Evansville, IN 47720.**

Delinquent Payments – Upon signing the Enrollment Form, each Member agrees to make quarterly payments for one calendar year, or 12 (twelve) consecutive months. These quarterly payments will be collected and coverage provided for the following quarter in which they are paid. In the event the insurance has not been used and a payment is not received by the 17th of the month, the coverage will cease without notice to the Member, and the Member will not be allowed to participate in the Plan for the remainder of the year. In addition, if you receive benefits during the calendar year, you will be required to pay the delinquency and remain in the Plan for the remainder of the year. The quarters of coverage are as follows: January, February and March; April, May and June; July, August and September; October, November and December. **In addition, delinquent payments to the Plumbers & Steamfitters Local Union No. 136 Voluntary Dental and Vision Plan shall be payable before per capita dues and/or assessments, even if it results in the member's delinquency or expulsion.**

Persons Covered – The Member will choose, at the time of his or her enrollment, as to what family member will receive coverage. The options include: 1) Member Only; 2) Member/Spouse; 3) Member/Children; 4) Member/Family. The option selected shall be in effect during the enrolled year, and if so desired, may be changed for the following calendar year during re-enrollment to the Plan or upon a qualifying event.

Coverage Offered – Dental and vision coverage is offered; the Member can select to participate in both the dental and vision, or can choose either the dental or vision. This selection will be made at the time of enrollment and will continue throughout the enrolled year. If so desired, this selection can be changed for the following calendar year during re-enrollment to the Plan.

Premium Amounts – Premium amounts for the various options offered will be provided to the Member at the time of enrollment. Billing will be combined to include dental and vision if the Member chooses to participate in both.

Safety Glass Coverage – Safety glass coverage is not available.

I understand that my coverage becomes effective January 1, 2024, only if I have signed and returned page 3 of the Plumbers & Steamfitters Local Union No. 136 Voluntary Dental and Vision Plan Contract and also paid my first quarterly statement that will be mailed December 14, 2023 and due by December 31, 2023.

SIGNATURE PAGE

SIGN AND RETURN FOR 2024 VISION AND/OR DENTAL INSURANCE

Acceptance of Terms – I have read the above-listed terms of the Plumbers & Steamfitters Local Union No. 136 Voluntary Dental and Vision Plan and agree to accept and abide by the terms as stated herein.

Printed Name:_____

Signature: _____Date_____
(Member)

The Voluntary Dental and Vision Plan will be effective upon the date of execution by an authorized representative of Plumbers & Steamfitters Local Union No. 136.

_____ Date: _____
John Bates

DELTA DENTAL®

Eligibility Enrollment/Update

No form is required if waiving benefits

Check: ☒ **Indiana** ☐ **Michigan** ☐ **Ohio** ☐ **North Carolina**

Dental Group #/Subgroup #: _____ - _____

Group Name: _____

Vision Group #/Subgroup #: _____ _____

Plan Enrollment/Update Information *(Please indicate type of update and fill in appropriate information)*:

Type of Update: ☒ New Enrollment ☐ Termination of Benefits ☐ Change/Correction to Information ☐ Reinstatement

Coverage Effective Date: 1/1/2024 ~~**Change is for:** ☐ Subscriber ☐ Spouse ☐ Dependent~~

Group/Subgroup Transfer

From (Group#/Subgroup#): _____ - _____ **To** (Group#/Subgroup#): _____ - _____

Subscriber Information *(Please fill in for first-time enrollments, changes, or corrections)*:

Subscriber Name

_____ _____ _____
(Last) *(First)* *(M.I.)*

Date of Hire: _____

☐ Dental ☐ ~~Vision (only available if the group contract includes it)~~

Social Security Number _____ Date of Birth _____

Sex: ☐ Male ☐ Female

Status*: ☐ Active ☐ ~~COBRA~~ ☐ Retiree ☐ ~~Surviving~~

Street Address

_____

☐ Check here if this is a new address

City _____ State _____ Zip Code _____

Spouse/Dependent Information ~~*(Please fill in for first-time enrollments, changes, or corrections)*~~:

Spouse Name

_____ _____ _____
(Last) *(First)* *(M.I.)*

☐ Dental ☐ ~~Vision (only available if the group contract includes it)~~

Social Security Number _____ Date of Birth _____

Sex: ☐ Male ☐ Female

Status*: ☐ Legal ☐ Surviving

Dependent #1 Name

_____ _____ _____
(Last) *(First)* *(M.I.)*

☐ Dental ☐ ~~Vision (only available if the group contract includes it)~~

Social Security Number _____ Date of Birth _____

Sex: ☐ Male ☐ Female

Status*: ☐ IRS Dep. ☐ Surviving ☐ Disabled ☐ Sponsored

Dependent #2 Name

_____ _____ _____
(Last) *(First)* *(M.I.)*

☐ Dental ☐ ~~Vision (only available if the group contract includes it)~~

Social Security Number _____ Date of Birth _____

Sex: ☐ Male ☐ Female

Status*: ☐ IRS Dep. ☐ Surviving ☐ Disabled ☐ Sponsored

Dependent #3 Name

_____ _____ _____
(Last) *(First)* *(M.I.)*

☐ Dental ☐ ~~Vision (only available if the group contract includes it)~~

Social Security Number _____ Date of Birth _____

Sex: ☐ Male ☐ Female

Status*: ☐ IRS Dep. ☐ Surviving ☐ Disabled ☐ Sponsored

Dependent #4 Name

_____ _____ _____
(Last) *(First)* *(M.I.)*

☐ Dental ☐ ~~Vision (only available if the group contract includes it)~~

Social Security Number _____ Date of Birth _____

Sex: ☐ Male ☐ Female

Status*: ☐ IRS Dep. ☐ Surviving ☐ Disabled ☐ Sponsored

*See reverse side for instructions.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

~~I authorize payroll deduction from my earning for any contribution I am required to make.~~

Subscriber's Signature: _____ **Date:** _____

AnthemLife

Plumbers and Steamfitters Local 136

Group Number : W12816

Personalized Enrollment Form

EMPLOYEE INFORMATION. Please verify the information below for accuracy. If incorrect, please contact your HR representative.

Name/Address	Date of Birth	Employee ID/SSN
	Division	Date of Hire
	BillClass	SubGroup
	Effective Date 1/1/2024	Gender

PLEASE PRINT IN BLACK OR BLUE INK. Read and complete all of this form. Please complete all grayed sections. If you need more space, attach a separate sheet of paper. Please use four digits for years (e.g. 1998, not 98).

Are you actively at work?	**Yes**	☐	**No**	☐				
Are you retired?	**Yes**	☐	**No**	☐				
Marital status:	**Single**	☐	**Married**	☐	**Widowed**	☐	**Divorced**	☐

Occupation: _____

Phone: _____

~~**Hours per week working for this employer:**~~ _____ **Email Address:** _____

BENEFIT SELECTION. Check the boxes that apply along with the appropriate coverage level.

Voluntary Vision

Consider how important good vision is to everyday activities like driving, shopping or watching a movie. Taking care of your vision is essential to your overall health and well-being. Did you know that having regular eye exams can reduce the risk of more serious, long-term diseases?

Accept	Decline	Coverage Level	Monthly Premium
☐	☐	Employee	$8.09
☐	☐	Employee + Spouse	$16.18
☐	☐	Employee + child(ren)	$17.32
☐	☐	Family	$27.65

DEPENDENT DESIGNATION

(Complete all details for Individuals applying for coverage: list names of all dependents.)

Last name, First name, M.I.	SSN (XXX-XX-XXXX)	Sex	Date of Birth (XX-XX-XXXX)	Age	Relationship (spouse/domestic partner or child)
	- -	☐ M ☐ F	/ /		Spouse/Domestic Partner
	- -	☐ M ☐ F	/ /		Child
	- -	☐ M ☐ F	/ /		Child
	- -	☐ M ☐ F	/ /		Child
	- -	☐ M ☐ F	/ /		Child

List address of all dependents if different from the applicant, including temporary address, e.g. college student.

Name/Address: _____ / _____

Name/Address: _____ / _____

ELIGIBILITY AND AUTHORIZATION

Employee Confirmation

My signature certifies that I (1) Apply for the coverages designated for which I am eligible under my employer's plan with the carrier. (2) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health to the carrier. ~~(3) Authorize any required deductions from my earnings~~. (4) Designate the beneficiary named on this application to receive any benefits payable in the event of death. (5) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. ~~(6) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured.~~

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 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 subjects such person to criminal and civil penalties.

Employee Signature _____ Date _____ / _____ / _____

Premium calculations above may differ slightly based on rounding rules and other system factors, but will not vary significantly. Every effort has been made to match your premiums to the penny.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing false, incomplete, or misleading information commits a felony.

Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningun costo adicional llamando al número de servicio al cliente que se encuentra en este documento.