Application for Vision Care Benefits

Underwritten by Fidelity Security Life Insurance Company
Kansas City, Missouri 64111

I. GROUP INFORMATION

Group Name: San Bernardino County Tax ID#: 95-6002748

DBA Name (If other than above): _____

Business Physical Address: 175 West 5th Street First Floor (Street Address) San Bernardino (City) CA (State) 92415 (Zip)

Mailing Address: _____ (Street Address) _____ (City) _____ (State) _____ (Zip)

Day-to-Day Contact Name: Sandra wakcher Title: Benefits Cheif

Phone Number: (909) 387-9676 E-Mail Address: sandra.wakcher@hr.

Type of Business: ☐ Proprietorship ☐ Corporation ■ Other (Specify): Government

PLEASE NOTE THE FOLLOWING TYPE BUSINESSES REQUIRE PRIOR CARRIER APPROVAL:

☐ MEWA ☐ PEO ☐ Trust ☐ Union ☐ VEBA ☐ Casino/Indian Tribe

Service Area: ☐ National *(U.S.– does not include Puerto Rico)* ☐ State Specific*
☐ National *(U.S.– does include Puerto Rico)*

If any subsidiary or affiliated companies are to be insured or any Employees/Members are working or residing in a state other than the business address above,* ***please list those states:* _____

Number of employees/members with language preferences other than English for oral or written communications:

Spanish _____ Oral _____ Written Chinese _____ Oral _____ Written Other _____ Oral _____ Written

GROUP DISPLAY NAME ***(Your Group Name as it should appear to your Employees/Members)***

Company Name: San Bernardino County

(Maximum of 40 characters, including capitalization, punctuation and spacing.)

II. GROUP BILLING

Billing Physical Address: 175 West 5th Street First Floor (Street Address) San Bernardino (City) CA (State) 92415 (Zip)

Primary Contact Name: Sandra Wakcher Title: Benefits Cheif

Phone Number: (909) 387-9676 E-Mail Address: sandra.wakcher@hr.sbcounty.gov

Do you have any additional subsidiaries, affiliated companies, or divisions that use another name and will be covered by this plan AND require separate billing invoices? ☐ Yes ☐ No If Yes, please attach and send a separate page signed by you with the following information: Name, Address, Billing Contact Name and Phone Number

III. PREMIUMS*

Please indicate the percentage of premium contributed by the Group and the Employee/Member for both the Employee/Member and Dependents; the total for each row must equal 100%.

	Group Contribution	Employee/Member Contribution
Employee/Members:	100 %	0 %
Dependents:	0-100 depends on unit %	0-100 depends on unit %

Are Employee/Member and Dependent premiums paid through a Section 125 Plan? ■ Yes ☐ No

Are Employee/Member and Dependent premiums collected via payroll deduction? ■ Yes ☐ No

Premiums shall be payable at the rates included on the attached proposal page.

**If the Group's contribution percentage is changed or the number of eligible Employees/Members increases or decreases, premium may be adjusted as allowed under the Policy. The premium may be adjusted at the end of the calendar month in which the change occurred.*

IV. ELIGIBILITY

Number of Eligible Employees/Members: 14,688

Will this plan replace any existing vision coverage? ☐ Yes ☐ No

If "Yes," name of existing insurer: _____

Eligible Class(es) of Employees/Members (please check all that apply):

☐ Active employees ☐ Retiree / Leave of Absence

■ COBRA–eligible employees ☐ Other: _____

Are the following covered under the plan:

Dependent Children Covered to Age*: ■ 26** ☐ Other _____

Dependent Children who are full-time students covered to age*: ☐ 27 ■ Other 26

Dependent Child Age Termination based on:

☐ Day Age is attained ☐ End of Month Age is attained ☐ End of Year Age is attained

**Unless state law has different requirements.*

***Dependent Children covered to age 26 regardless of financial dependency, residency, student status or marital status.*

MEMBERSHIP INFORMATION

Who will send enrollment for Active Employees/Members? ■ Group ☐ Group's TPA

If TPA, TPA Name: _____

Group/TPA Contact Name: Janet Rodriguez

Phone Number: (909) 387-5812 E-Mail Address: janet.rodriguez@hr.sbcounty.gov

Membership will be an electronic membership file? ☐ Yes ☐ No

Who will send enrollment for COBRA Employees/Members? ☐ Group ☐ Group's TPA

If TPA, TPA Name: _____

Group/TPA Contact Name: _____

Phone Number: ( ) _____ E-Mail Address: _____

Membership will be an electronic membership file? ☐ Yes ☐ No

PROBATIONARY PERIOD

For New Employees/Members: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days ☐ Other _____

Probationary Period is waived for present Employees/Members: ☐ Yes ☐ No

Number of Employees/Members who have not yet completed the probationary period: _____

V. PLAN SELECTION

Please refer to the attached proposal page. Services are provided by EyeMed Vision Care.

VI. EFFECTIVE DATE

This Policy will become effective at 12:01 a.m. Local Time at the Group's address herein, on

7/29/2023 , provided all the following has been completed prior to this effective date:
MM/DD/YYYY

A. This application has been received and accepted by the Company (must be submitted 30 days in advance of the effective date).

B. EyeMed has been furnished a working file of all eligible Employees/Members, in an agreed upon format. It is understood and agreed that EyeMed may rely on this information to provide services to individuals designated as eligible.

The Group hereby makes application to Fidelity Security Life Insurance Company for Vision Care Benefits. The Group agrees to maintain and furnish any records necessary to administer this plan and to pay premiums monthly.

The Group certifies that all information shown on this application and any attachments is correct and complete to the best of the Group's knowledge and belief as of the date this application is signed. The Group understands that the Company intends to rely on this information in determining if the enrolling Employees/Members and their Dependents may become insured. It is further understood and agreed that **NO INSURANCE WILL BECOME EFFECTIVE UNTIL APPROVED BY THE COMPANY**; and that no field representative of the Company has the authority to modify any conditions of the application or the Policy by making any promise or representation.

The falsity of any statement in this application will not bar the right to recovery under the Policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the Company.

ELECTRONIC TRANSMISSION OF DOCUMENTS: The Group agrees to voluntarily receive all documents and correspondence electronically and that the Group can access the internet or the email address provided. Written notice of termination will be provided to the Group as shown in the Policy. The Group understands that the Group may revoke this authorization, report a change or correction to the email address provided or request specific paper documents without revoking this authorization by contacting the Company or EyeMed by mail, email, or by telephone at 800-648-8624.

☐ Yes Email Address: _____ ■ No

Dated at: San Bernardino CA (City) (State) this 15th (Day) day of May (Month), 2023 (Year)

Signed for the Group: ▶ DocuSigned by: Sandra Walker 55679295A8504B9... Title: Division Chief

Printed Name: Sandra Walker

ATTENTION: THE DEPARTMENT OF INSURANCE REQUIRES THAT ONLY THE BROKER AND/OR GENERAL AGENT WHO SOLD THE PRODUCT AND HOLDS A VALID LIFE AND HEALTH LICENSE MAY COMPLETE THE CERTIFYING STATEMENT

WRITING BROKER'S CERTIFYING STATEMENT

I certify that I am properly licensed in the state in which the Group is domiciled and I have accurately recorded on this application the information supplied by the applicant, if such information has been provided directly to me for recording purposes, to the best of my knowledge and belief the information on the application is complete and accurate, that I explained in easy to understand language the risk to the applicant of providing inaccurate information and that the applicant understood the explanation and that if I willfully state as true any material fact I know to be false, that I shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars ($10,000). Any public prosecutor may bring a civil action to impose that civil penalty. These penalties shall be paid to the Insurance Fund.

Firm Name (print): Segal Western States Tax ID No.: 94-1503999

Mailing Address: 500 N Brand Blvd, Ste 1400 (Street Address) Glendale (City) CA (State) 91203 (Zip)

Day-to-Day Contact Name: _____ Title: _____

Day-to-Day Contact Phone Number: (818) 956-6700 Day-to-Day Contact E-Mail Address: _____

Commission checks payable to: ☐ Firm ☐ Broker

Broker Name (print): Robert Mitchell SS#: 94-1503999

Broker Phone Number: (818)956-6700 Broker E-mail Address: rmitchell@segalco.com

Broker Signature: ► _____

WRITING GENERAL AGENT'S CERTIFYING STATEMENT

I certify that I am properly licensed in the state in which the Group is domiciled and I have accurately recorded on this application the information supplied by the applicant, if such information has been provided directly to me for recording purposes, to the best of my knowledge and belief the information on the application is complete and accurate, that I explained in easy to understand language the risk to the applicant of providing inaccurate information and that the applicant understood the explanation and that if I willfully state as true any material fact I know to be false, that I shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars ($10,000). Any public prosecutor may bring a civil action to impose that civil penalty. These penalties shall be paid to the Insurance Fund.

Firm Name (print): _____ Tax ID No.: _____

Mailing Address: _____ (Street Address) (City) (State) (Zip)

Day-to-Day Contact Name: _____ Title: _____

Day-to-Day Contact Phone Number: ( ) Day-to-Day Contact E-Mail Address: _____

Commission checks payable to: ☐ Firm ☐ General Agent

General Agent Name (print): _____ SS#: _____

General Agent Phone Number: ( ) General Agent E-mail Address: _____

General Agent Signature: ► _____