Supplemental Benefit Employer Trust
Existing Group Employee Vision Application/Change Form

Company Name: Greenville Rancheria **Customer Number:** 00204540

Please fax this application to Beneficial Administration Company at (949) 724-1603.

1. Enrollment Status (check one)

- ☐ New Hire Enrollment
- ☐ Family Addition: Date of Marriage _____
- ☐ Family Addition: Date of Birth or Adoption _____
- ☐ Cal-COBRA Effective date _____
- ☐ COBRA Effective date _____

2. Employee Information

Last Name	First Name	Middle Initial	Gender (M/F)

Social Security Number	Date of Birth (MM/DD/YY)
_____ - _____ - _____	_____ / _____ / _____
Marital Status: ☐ Single ☐ Married ☐ Divorced	Number of Eligible Children *: _____

Home Street Address (P.O. Box not acceptable unless Rural P.O. Box)	Apt. Number

City	State	Zip Code	Home Phone
			(_____) _____ - _____

Job Title	Date of Hire (MM/DD/YY)	Business Phone	Hours Worked per Week
	_____ / _____ / _____	(_____) _____ - _____	

3. Dependent Information: An employee may only enroll his/her dependent(s) if the following criteria is met:

*An eligible dependent is an employee's spouse/domestic partner; any unmarried child of the enrolled applicant or spouse/domestic partner who is under age 19; or any unmarried child of the enrolled applicant or spouse/domestic partner who is age 19 until age 25, provided the child is a full time student and fully dependent upon the employee for support. *Enrollment on this plan is determined by the employer's participation selection.*

Last Name	First Name	Birthdate (MM/DD/YY)	Full Time Student?
☐ Husband ☐ Wife ☐ Domestic Partner		_____ / _____ / _____	Not Applicable
☐ Son ☐ Daughter		_____ / _____ / _____	(Please circle) Yes or No
☐ Son ☐ Daughter		_____ / _____ / _____	(Please circle) Yes or No
☐ Son ☐ Daughter		_____ / _____ / _____	(Please circle) Yes or No
☐ Son ☐ Daughter		_____ / _____ / _____	(Please circle) Yes or No

4. Authorization: (The following authorization section must be signed by the employee applying for coverage.)

I understand that my employer is applying for membership in the Supplemental Benefit Employer Trust (the "Trust") and I am simultaneously applying for insurance for which I am now or may be eligible for under the provisions of the Vision Benefit Plan issued to that Trust by Vision Service Plan. I understand that my insurance will not be in force until the application is approved by Vision Service Plan or their authorized Administrator in accordance with the underwriting guidelines in effect. I understand that acceptance of the check submitted with the application does not constitute approval or guarantee of coverage.

I understand that some of the contracts Warner Pacific Insurance Services, Inc. ("Warner Pacific") holds with insurance carriers allow incentives, bonuses and excess surplus compensation ("compensation"). In the sole and exclusive discretion of Warner Pacific, such compensation may be retained by Warner Pacific or paid to other parties. Such compensation will not be returned to you or your dependents. Any vision benefits claims submitted under your policy/certificate will be paid without regard to such compensation.

I agree that all information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. I further authorize my employer to deduct from my earnings the contribution (if any) required to apply toward the cost of this plan.

I understand that my employer's application will determine coverage and that there is no coverage unless and until this application and an application made by my employer have been accepted and approved by Beneficial Administration Company and/or Vision Service Plan.

Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy being rescinded.
I, the applicant, acknowledge that I have read and understand this application in its entirety.

Signature of Employee: _____ Date: _____