



VSP/UNUM Employer Group Application + Participation Guidelines

You have received this information under the assumption that you are an asba member.

You are now eligible for the VSP and UNUM insurance programs on 1st of the month following 90 days of ASBA membership.

Name of Company: _____

Nature of Business: _____

Address: _____

Phone #: _____ Fax #: _____

Email: _____

Contact Name: _____ Date joined ASBA : _____

Total # of employees _____ #Full-Time _____ #Part -Time _____

Contribution Percentage: Employee _____ Dependent _____

Please initial these items and return this form along with your application and payment.

- _____ I understand that there is a monthly administration charge of \$6.00.
- _____ I understand that my benefits will be cancelled should this administration charge not be paid each month.
- _____ I understand that there is a late fee charge of \$15.00 if the premium is not paid by the 10th of the current month.
- _____ I understand that my benefits could be terminated if this late fee charge is not paid.
- _____ I understand that if my premium check is ever returned for "insufficient funds" that there will be an additional charge of \$35.00.
- _____ I understand that if this "insufficient funds" charge is not paid, my benefits could be terminated.
- _____ I understand that the second month's premium initially submitted with my application is, in fact, the escrow premium that is used to pay either my premium, should I be late, or my last month's premium should I terminate. If coverage is terminated due to lack of payment this is not considered a COBRA qualifying event and coverage cannot be reinstated until the next open enrollment.
- _____ I understand that if the escrow is used to pay my premium, it must be replaced along with any additional fees by the end of the month it has been applied to or my benefits could be terminated.
- _____ My company is an ASBA member and we have satisfied the 90 day waiting period.
- _____ Employers must contribute 100% of the life insurance premium (if elected).
- _____ An employee/employer relationship must exist between the employer and employees eligible for coverage.

Signature _____ Title _____ Date _____

This form must be returned along with your application in order to be processed.