26050 Mureau Road, Suite 220, Calabasas, CA 91302 • 818-591-8700 • Fax: 818-591-8722 • www.aaqhc.com

APPLICATION FOR GROUP COVERAGE: MESVision

Group Applicant

Full Legal Name of Employer/Group:		SIC:
Group Contact:	Email address:	
Address (Street):		Telephone:
City:	State:	Zip Code:

Legal Entity
☐ Corporation ☐ S-Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Trust ☐ Association ☐ Other:

Nature of Business:

Subsidiaries or Affiliates to be Insured: ☐ No ☐ Yes – Full Legal Name(s):
1.
2.

Coverage Requested

(Benefit Frequency, Frame Allowance, Contact Lens Allowance) 1. Plan:	2. Requested Effective Date:
3. Number of Eligible Employees:	4. Number of Employees Enrolling:
5. Number of Eligible Dependents:	6. Number of Dependents Enrolling:

7. Waiting Period: Initial Employees: ☐ None Future Employees: ☐ One Month ☐ Other:

8. Employer Contribution: % Employee / % Dependents

9. All or part of this insurance will replace similar coverage:
☐ No ☐ Yes, please submit copies of the policy(ies) and/or certificate(s)
Prior Carrier: Coverage: Termination Date:

10. Initial Premium Deposit: Minimum First Month Premium, Plus $ __________ Enrollment Fee
TOTAL REMITTED $_______________

Agreement

To the best of our knowledge and belief, all information on this application is true and complete. If the application is not complete, AAQHC, An Administrator, reserves the right to reject it and notify in writing. We understand that no coverage will be effective before the date determined by AAQHC, An Administrator, and only if we have paid our first month's contribution plus AAQHC dues and fees.

Authorization

Dated at: (City) (State)	This: (Month) (Day) (Year)
Witness (Licensed Broker/Agent):	By (Authorized Signature):
Print Broker/Agent Name:	Print Name:
Broker/Agent License Number:	Title:

©2017 Unico American Corporation