VISION WRAP CHECKLIST

General Information

Employer's Full Name: _____

Address: _____

_____

Telephone: _____

Employer Identification Number: _____

Plan Sponsor *(if different from Employer)*: _____

Plan Administrator *(if different from Employer)*: _____

Plan Year: _____ through _____

ERISA Plan Number: _____

Agent for Service of Process: _____

Address: _____

_____

Telephone: _____

Trustees *(if any)*: _____

Address: _____

_____

Telephone: _____

Title or Name of Contact Person for Questions: _____

Telephone: _____
Fax: _____
Email: _____

Original Effective Date: _____

Restated Date: _____
(Date when you plan to distribute this document – must be at least 20 days following submission)

Participating Employer(s): _____
_____
_____

(Employers whose employees are eligible to participate in this plan – must be affiliated companies – if you are unsure whether the entities meet ERISA's requirements for affiliation, please describe the relationship.)

Does HIPAA apply to the Employer(s)? Yes _____ No _____
(HIPAA applies to group health plans and group health insurance coverage for any plan year if, on the first day of the plan year, the plan has 2 or more participants who are current employees. It does not apply to any plan or coverage providing "excepted benefits," which include limited scope dental or vision benefits if offered separately from any other benefits.)

Does COBRA apply to the Employer(s)? Yes _____ No _____
(COBRA applies to all group health plans maintained by all public and private employers, other than churches; governmental entities of the U.S., the District of Columbia and U.S. territories and possessions; state and local government agencies that are not recipients of PHSA fund; and employers, including related employers, whose total number of employees (full-time and part-time), including leased employees, was less than 20 on at least 50% of the typical business days in the prior calendar year.)

Does FMLA apply to the Employer(s)? Yes _____ No _____
(FMLA applies to private sector employers of 50 or more employees and public agencies.)

Is this a Union Plan (maintained pursuant to a collective bargaining agreement): _____
If so, what is the Name of the Union: _____
If so, what is the Local Number: _____
If so, what is the Local Location: _____

Is this a Government Plan: _____
If so, is HIPAA applicable: _____
(A "Government Plan" is any plan established or maintained for its employees by the U.S. Government, the government of any state or political subdivision thereof, or by any agency or instrumentality of the foregoing. It also includes any plan to which the Railroad Retirement Act of 1935 or 1937 applies, and which is financed by contributions required under that Act, and any plan of an international organization which is exempt from taxation under the provisions of the International Organizations Immunities Act.)

Is this a Church Plan: _____
If so, is HIPAA applicable: _____
(A "Church Plan" is a plan established and maintained for its employees or their beneficiaries by a church or by a convention or association of churches which is exempt from tax under §501 of the Internal Revenue Code of 1954 ("IRC"). It does not include a plan where the employees or their beneficiaries are employed in connection with one or more unrelated trades or businesses (as described in IRC §513) or if less than substantially all of the individuals included in the plan are employees or beneficiaries. "Employee" means a duly ordained, commissioned or licensed minister of a church in the exercise of his ministry, regardless of the source of his compensation, or an employee of an organization which is exempt from tax under IRC §501 and which is controlled by or associated with a church or a convention or association of churches.)

Type of Benefit Plan: ***(Please list FULL name of plan (i.e., PPOBlue High Option II, Keystone HMO, etc.):***

_____

Address: _____

_____

Telephone: _____

Please enclose a copy of your most recent benefit materials received from Highmark, Concordia, Fashion Advantage, VBA, etc.

Are employees required to contribute for their coverage? Yes ____ No ____

Are employees required to contribute for dependent coverage? Yes ____ No ____

Definitions

"Employee" means a person who is a regular full-time *employee* of the *participating employer*, regularly scheduled to work for the *participating employer* in an employer-*employee* relationship. Such person must be scheduled to work at least [_____] hours per week and at least [_____] months per year in order to be considered "full-time."

Eligibility for Coverage

Can an individual be covered simultaneously as an Employee and a Dependent? Yes ____ No ____

Does this Plan have an Open Enrollment Period? _____. If so, please complete the blanks.

Coverage for Participants enrolling during an Open Enrollment Period will become effective on [_____] 1, unless the Employee has not satisfied the Service Waiting Period, in which event coverage for the Employee and his Dependents will become effective on the day following completion of the Service Waiting Period.

"Open Enrollment Period" shall mean the month of [_____] in each Plan Year.

Loss of Other Coverage
An *employee* who is already enrolled in a benefit package may enroll in another benefit package under the *Plan* if a *dependent* of that *employee* has a special enrollment right in the *Plan* because the *dependent* lost eligibility for other coverage. The *employee* must make written application for special enrollment in the new benefit package within 30 days of the date the other health coverage was lost.
OPTIONAL – KEEP or REMOVE

New Dependent
If the conditions for special enrollment are satisfied, coverage for the *employee* and his or her *dependent(s)* will be effective at 12:01 A.M.:

For a marriage, on the…

	…date of the marriage.
	…first day of the calendar month following enrollment.

	Other:

Termination of Coverage

Termination Dates of Individual Coverage

Do benefits terminate on the:

	DATE of the month in which the event occurs
	LAST DAY of the month in which the event occurs

If an Employee is a member of the armed forces, is he or she still eligible for coverage under the plan?
Yes ____ No ____

If a Dependent is a member of the armed forces, is he or she still eligible for coverage under the plan?
Yes ____ No ____

Continuation of Coverage

Employer Continuation Coverage
Is coverage continued in the event of:

Yes	No	Item	For How Long
		Layoff	
		Total Disability – Temporary (3 months or less)	
		Total Disability – Permanent (more than 3 months)	
		Leave of Absence which does not meet the requirements of FMLA Leave	

Qualifying Events
Is legal separation a qualifying event? _____

Are Retirees eligible for coverage: Yes ____ No ____

How long does *COBRA continuation coverage* last?
When the *qualifying event* is "entitlement to *Medicare*," the 36-month continuation period is measured from the date of the original *qualifying event*.
OPTIONAL – KEEP or REMOVE

HIPAA Privacy

Please list the TITLES ONLY of those persons who will have access to PHI. ***This list is REQUIRED, and must be in the Plan (reference to a website is not acceptable):***

_____ _____

_____ _____

_____ _____

_____ _____