APPLICATION FOR VISION CARE PLAN (StdPrm)

vsp vision care

Attn: Sales
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 216-6248

Complete all applicable questions accurately and in detail.

CLIENT INFORMATION

1	Full legal name of client as it will appear on the policy: City of Broken Arrow			
	Address: 220 S. First Street			
	City: Broken Arrow	County:	State: OK	ZIP: 74012
	Phone: 918-259-2400	Fax:		
	Principal Contact: KELLY COX		Title: DIRECTOR OF HR	
	Phone: 918-259-6508	Fax:	E-mail: kcox@brokenarrowok.gov	
	Client is headquartered in state of *OK* (if different state from section 1, provide physical address for client in this state)			
	Address:			
	City:	County:	State:	ZIP:
2	Who should we contact with payment questions?			
	Name:		Title:	
	Phone:	Fax:	E-mail:	
3a	Who should we contact with eligibility questions?			
	Name: JACQUE HULSEY		Title: BENEFITS ADMINISTRATOR	
	Phone: 539-357-1690	Fax:	E-mail: jhulsey@brokenarrowok.gov	
3b	Does your broker need access to view/manage/update your eligibility?		yes ☐ no ☒	
	Name:		Title:	
	Phone:	Fax:	E-mail:	
4	Who is the Benefit Administrator responsible for the overall administration of the plan (if not principal contact)?			
	Name: JACQUE HULSEY		Title: BENEFITS ADMINISTRATOR	
	Phone: 539-357-1690	Fax:	E-mail: jhulsey@brokenarrowok.gov	
	If multiple benefits administrators are at other locations, attach names, addresses, emails, phone, and fax numbers.			
5	What is the nature of your business? MUNICIPALITY What is the DUNS number? 73-6005109			
6	Membership information will be sent to VSP via: ☒ Electronic Transfers ☐ Online Eligibility Management			
	If electronic transfer reporting OR if a third party will handle your eligibility, please provide Third Party Administrator Information. Firm: EMPLOYEE NAVIGATOR / COLONIAL			
	Contact: Ryan Stribling		Title: Coordinator	
	Address:			
	City:	County:	State:	ZIP:
	Phone: 803-730-5046	Fax: 803-356-0083	E-mail: ryan.stribling@coloniallifesales.com	

In conjunction with health plan industry practices when providing electronic eligibility, VSP requests clients to send dependent eligibility information to VSP. This would include providing the covered dependent's full name, date of birth, and relationship to the employee/member. Dependents will be reported as a dependent under the employee's ID number.

Will dependent information be sent to VSP for eligibility purposes? ☒ yes ☐ no

If no, please explain:

Employers without Internet access for making membership updates will be contacted by VSP to review other options.

7a Is a COBRA division required? ☒ yes ☐ no

7b Names of separate divisions that require separate billing:
All Eligible Employees COBRA, City Manager COBRA, Police FOP COBRA, & Retirees COBRA

Address of additional divisions if applicable. **IMPORTANT:** Separate divisions will be billed on separate invoices
(*If multiple divisions are needed, attach list of division names, contact names, address, email, phone, and fax numbers*):

Billing address (if different than Client address):

City: County: State: ZIP:

Phone: Fax: E-mail:

If Self-Funded Program, do claims billings and administrative fee billings go to the same person? ☒yes ☐no

If no, please supply contact, title, address, phone, and fax number for each type of billing.

8 Number of employees eligible for benefits: 691

Does this represent the total number of employees in the company? ☐ yes ☒ no ☐ total number: 870

Do you have an employee population outside of the US? ☐ yes ☒ no If yes, what country :

Do you provide benefits to your retiree population? ☒ yes ☐ no

Dependents: Eligible dependents are the covered employee's spouse and unmarried dependent children until the end of the month that they reach their [**26**] birthday, or the end of the month that they reach their [**26**] birthday, if attending school full time.

(includes an unmarried child if incapable of self-support because of physical or mental incapacity that commenced prior to reaching the above age)

9 Dependents other than employee's spouse & children:

☐ domestic partners (all) ☐ domestic partner's children

☐ domestic partners (same sex only) ☐ parents (IRS qualified)

POLICY DETAILS

The rates listed must support the plan design and benefit selected and must meet all eligibility requirements. Please refer to your VSP-provided rate sheet for details or contact your VSP Account Executive. Any discrepancies may preclude acceptance by VSP.

10 Benefit Year (select one):

☐ Service Year (from last date of service)

☒ Calendar Year (**IMPORTANT:** Policy effective date and renewal date MUST be January 1)

11 Plan Type (select all that apply):

☒ Signature Plan	☐ Choice Plan	☐ Advantage
☐ Signature Exam Plus	☐ Choice Exam Plus	☐ Advantage Exam Plus
☐ Signature Exam Plus w/Allowances	☐ Choice Exam Plus w/Allowances	☐ Advantage Exam Plus w/Allowances
☐ Signature Materials Only	☐ Choice Materials Only	☐ Other:
☐ Signature EasyOptions	☐ Choice EasyOptions	

12 Is vision benefit:

☐ Core ***or*** ☒ Voluntary Employer contribution percentage: for employee: **0%** for dependent: **0%**

Standard Plan Frequency of Service (select one): ☐ B (12/12/24) ☒ C (12/12/12)

Total co-payment: **$25** (applies to exam and eyewear) ***or*** Split co-payment: $ exam / $ eyewear

☐ Scratch Coating ☐ Anti-Reflective Coating ☐ Progressive Lenses

☐ Photochromic ☐ Polycarbonate Lenses for Adults

☐ $120 ☒ $130 ☐ $150 ☐ $180 ☐ $200 ☐ $225 ***or*** ☐ $250 Elective Contact Lens Allowance

☐ $120 ☐ $130 ☐ $150 ☐ $180 ☒ $200 ☐ $225 ***or*** ☐ $250 Retail Frame Allowance

☐ Enhanced Featured Frame Additional $50 Allowance

13 Is vision benefit:

☐ Core ***or*** ☒ Voluntary Employer contribution percentage: for employee: **0%** for dependent: **0%**

Premium Plan Frequency of Service (select one): ☐ B (12/12/24) ☒ C (12/12/12)

Total co-payment: **$25** (applies to exam and eyewear) ***or*** Split co-payment: $ exam/$ eyewear

☐ Scratch Coating ☐ Anti-Reflective Coating ☐ Progressive Lenses

☐ Photochromic ☐ Polycarbonate Lenses for Adults

☐ $120 ☒ $130 ☐ $150 ☐ $180 ☐ $200 ☐ $225 ***or*** ☐ $250 Elective Contact Lens Allowance

☐ $120 ☐ $130 ☐ $150 ☐ $180 ☒ $200 ☐ $225 ***or*** ☐ $250 Retail Frame Allowance

☐ Enhanced Featured Frame Additional $50 Allowance

14 Specialty Care: Standard Plan: yes ☐ no ☒ Premium Plan: yes ☒ no ☐

☐ Covered Contact Lenses ☐ ProTec Safety

☒ **Second Pair of Glasses** ☐ Computer Vision Care

☐ Vision Therapy ☐ Preferred Laser Vision Care (Available to self-insured clients with 200+ enrolled)

☐ LightCare

☐ Other:

15 Requested effective date *(The effective date should not precede the date VSP receives this application.)*

This policy will become effective on the first day of [January] (month) [2026] (year), provided that all of the following has been completed prior to this effective date:

A. VSP has received and accepted this Application.

B. VSP has received and accepted Membership, including the required information of all employees that will be covered under this policy showing name, member ID, and number of dependents, if applicable.

16 Schedule A Information: Fiscal Year [ ] through [ ].

Schedule A will be sent to the person named as the principal contact. A copy of the report may also be sent to your broker and/or your third party administrator.

17 Do you currently have coverage: ☒ yes ☐ no If yes, current vision plan carrier:

If current carrier is VSP, please provide Client Name: **Ameritas**

18 Fully-insured programs:

Standard Plan Rates: **$9.81 $19.61 $20.99 $33.54**

Premium Plan Rates: **$14.57 $29.13 $31.17 $49.81**

19 Self-insured programs Administrative Fee:

Fixed fee: $ N/A or Percent of claims: N/A % or Dollars per claims: $ N/A

AGREEMENT

The undersigned client hereby applies for vision care coverage through VSP. It is understood that:

A. All future employees will be covered when they become eligible or offered VSP coverage if voluntary.
B. Coverage will terminate for an employee on the effective date indicated by the client.
C. Member past service for clients previously covered by VSP will carry over and remain in force.
D. Any non-VSP-created information outlining coverage or plan details must be reviewed by VSP prior to distribution to members.
E. This agreement will continue in force **48** months from the effective date. Rates are based on the assumption that VSP will receive these amounts over the full plan term.

This application signed this [ ] (day) of [September] (month) of [2025] (year).

Firm/Organization: City of Broken Arrow

Name: Debra Wimpee Title: Mayor

Signature:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.

BROKER/CONSULTANT

☒ The broker/consultant indicated below is hereby designated Broker of Record by the above signed employer.

Broker of Record Legal Firm Name: ALLIANT INSURANCE SERVICES INC

Address: 701 B Street, 6th Floor

City: San Diego County: State: CA ZIP: 92101

Licensed Producer's Name: BRADY AYALA Title: SVP, Employee Benefits

Phone: 405-607-7372 Fax: E-mail: brady.ayala@alliant.com

Additional contact name: Jenny Horn-Williams Phone: 405-607-7373 E-mail: Jenny.Horn-Williams@alliant.com

This application signed this [ ] (day) of [September] (month) of [2025] (year).

Signature of state-licensed agent:

Agent License #: 40046272

Agent NPN: 10725292

Please include a copy of agent/broker license, if not currently on file with VSP.

COMMISSION CHECKS PAYABLE TO

Commission Checks Payable to:

☒ Firm Name
☐ Contact Name
☐ Not Paid

Taxpayer ID: 33-0785439

Agency License #: 100103491

Agency NPN: 784013

☒ Corporation
☐ Independent

☐ Same as licensed producer listed above

☒ Other: Legal Firm Name: Alliant Insurance Services, Inc. Make checks payable to: AIS DB EB Op Account

Address: P.O. Box 745977

City: Los Angeles County: State: CA ZIP: 90074-5977

Phone: 737-236-5118 Fax: E-mail: Exie.Izaguirre@alliant.com

ACCOUNT MANAGEMENT / SERVICE / RENEWALS

BROKER/CONSULTANT LISTED BELOW TO RECEIVE CORRESPONDENCE

☒Same as licensed producer listed above
☐Other: Legal Firm Name:

State-licensed Agent / Contact Name:		License #:	
Address:			
City:	County:	State:	ZIP:
Phone:	Fax:	E-mail:	

If additional broker/consultant is to have access to this account, copy page and specify commission percentage split (if applicable).

Include copy of agent/broker license if not currently on file with VSP.