APPLICATION FOR VISION CARE PLAN

vsp vision care

Attn: Sales
3333 Quality Drive, Rancho Cordova, CA 95670
800.852.7600

Complete all applicable questions accurately and in detail.

CLIENT INFORMATION

1 Full legal name of client as it should appear on the policy: City of Fort Lauderdale

Address: 401 SE 21st Street

City: Fort Lauderdale | County: Broward | State: FL | ZIP: 33316

Principal Contact: Mikki Sampo | Title: Benefits Manager | Grant online access? Y

Phone: 954-828-5436 | Fax: 954-828-5328 | E-mail: msampo@fortlauderdale.gov

Client is headquartered in state of
(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: Melissa Ferrer | Title: Senior Accounting Clerk | Grant online access? Y

Phone: 954-828-5562 | Fax: 954-828-5328 | E-mail: melissaf@fortlauderdale.gov

3a Who should we contact with eligibility questions?

Name: Yslande Agenor OR Shane Meehan | Title: Benefits Specialist/Analyst | Grant online access? y

Phone: 954-828-5160 | Fax: 954-828-5328 | E-mail: yagenor@fortlauderdale.gov OR smeehan@fortlauderdale.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: | Title: | Grant online access?

Phone: | Fax: | E-mail:

If multiple benefits administrators are at other locations, attach names, addresses, emails, phone, and fax numbers.

5 What is the nature/type of your business? Government | What is the DUNS number? 072219595

Standard Industry Code (SIC): | Division: | Major Group:

6 Membership information will be sent to VSP via: ☒Electronic Transfers ☐Online Eligibility Management

Membership information will be reported using ☒Member SSNs ☐Unique member IDs

If electronic transfer reporting OR if a Third Party Administrator will handle your eligibility, please provide their information. Firm: Selerix

Contact: Jennifer Buchman-Snyder | Title: Client Success Executive | Grant online access? Y

Address:

City: | County: | State: | ZIP:

Phone: (214) 856-4200 ext. 886 | Fax: | E-mail: jennifer.buchman-snyder@selerix.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.

7 Is a COBRA division required? ☒yes ☐no

Names of additional divisions that require separate billing.

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, email, phone, and fax number for each type of billing.

8 Number of employees eligible for benefits: 1850

Does this represent the total number of employees in the company? ☐yes ☒no total number: 3300

Do you have an employee population outside of the US? ☐yes ☒no

If yes, what countries? number eligible?

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

Dependents: Eligible dependents are the covered employee's spouse and ☒unmarried and/or ☒married dependent children until the ☐date of birth OR ☐end of the month OR ☒end of the year that they reach their [26] birthday (also includes a child if incapable of self-support because of physical or mental incapacity that commenced prior to reaching the above age), and full-time students until the ☐date of birth OR ☐end of the month OR ☒end of the year that they reach their [30] birthday.

9 Dependents other than employee's spouse & children:

☐parents ☒domestic partners (all)

☐domestic partners (same sex only) ☒domestic partner's children

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)

☐Plan Year (from effective date of contract)

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 ☒Voluntary ☐Packaged with medical and/or dental

If **Voluntary** (vision is included as a stand-alone menu item in a list of benefits to choose from.):

Employer contribution percentage: for employee: 0% for dependent: 0%

Voluntary Participation Structure: *A minimum number of enrolled employees may apply.

☐Exam w/Voluntary Materials* ☒Voluntary Pool 0-24% employer contribution*

☐Voluntary Pool 25% or more employer contribution* ☐Core Employee/Voluntary Dependent Coverage*

If **Core Plus Options** (group provides a basic level of vision coverage to all employees with an option for the employee to buy up or enhance the benefit):

Employer contribution percentage: for employee: % for dependent: %

If **Packaged** (vision is tied to which of the following benefits: ☐medical ☐dental

13 Frequency of Service (select one): **High Plan**

☐A (12/24/24) **(IMPORTANT:** 12/24/24 is not available on voluntary plans) ☒B (12/12/24) ☐C (12/12/12)

☐ Materials Only (select one): ☐ (_/12/12) ☐ (_/12/24) ☐ (_/24/24)

☐Other:

Copayment(s) (select one):

☐ None

☐ Total co-payment: $ (applies to exam and eyewear) ☒ CLEX $60 or Other $

OR

☒ Split co-payment: $0 exam / $25 eyewear

14a Client has purchased Enhancements or Specialty Care: yes☐ no☒ Buy-up Plan: yes☒ no☐

Description:

☐ Anti-Reflective Coating
with $ copay or $ allowance

☐ Photochromic
with $ copay or $ allowance

☐ Progressives Premium and Custom
with $ copay or $ allowance

☐ Other:

☐ Covered Contact Lenses
☐ Scratch Coating
☐ Second Pair of Glasses
☐ Retinal Imaging
Copay: $

☐ Preferred Laser VisionCare
☐ ProTec Safety
☐ Vision Therapy
☐ Computer VisionCare
☐ Essential Medical Eye Care
☐ LightCare
☐ Repair/Replace
☐ KidsCare
☒ Standard Progressive

14b Elective Contact Lens (Materials Allowance): ☐$120 ☐$130 ☐$140 ☐$150 ☐$180 ☒other: $260

Frame (Retail Frame Allowance): ☐$120 ☐$130 ☐$140 ☐$150 ☐$180 ☒other: $260

☐Enhanced Featured Frame Additional $50 Allowance

15 Frequency of Service (select one): **Low Plan**

☐A (12/24/24) **(IMPORTANT:** 12/24/24 is not available on voluntary plans) ☒B (12/12/24) ☐C (12/12/12)

☐ Materials Only (select one): ☐ (_/12/12) ☐ (_/12/24) ☐ (_/24/24)

☐Other:

Copayment(s) (select one):

☐ None

☐ Total co-payment: $ (applies to exam and eyewear) ☒ CLEX $60 or Other $

OR

☒ Split co-payment: $10 exam / $25 eyewear

16 Client has purchased Enhancements or Specialty Care: yes☐ no☒ Buy-up Plan: yes☐ no☒

Description:

17 ☐ Anti-Reflective Coating
with $ copay or $ allowance

☐ Photochromic
with $ copay or $ allowance

☐ Progressives Premium and Custom
with $ copay or $ allowance

☐ Covered Contact Lenses

☐ Scratch Coating

☐ Second Pair of Glasses
☐ Retinal Imaging
Copay: $
☐ Preferred Laser VisionCare
☐ ProTec Safety
☐ Vision Therapy
☐ Computer VisionCare
☐ Essential Medical Eye Care
☐ LightCare
☐ Repair/Replace
☐ KidsCare
☒ Standard Progressive
☐ Other:

18 Elective Contact Lens (Materials Allowance): ☐$120 ☒$130 ☐$140 ☐$150 ☐$180 ☐other: $

19 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.

This agreement will continue in force [36] months from the effective date. Rates are based on the assumption that VSP will receive these amounts over the full plan term.

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.

For fully-insured programs (VSP will bill you for your first month's premium)

	High Rates
Employee-only or composite rate basis	$ 7.89
Two-rate basis	$ 15.78
Three-rate basis	$ 16.89
Four-rate basis	$ 26.99

Low Rates

Employee-only or composite rate basis	$ 4.58
Two-rate basis	$ 9.15
Three-rate basis	$ 9.79
Four-rate basis	$ 15.65

IMPORTANT: Sold rates are required

For self-insured programs, Administrative Fee:

Fixed fee: or Percent of claims: % or Dollars per claims: $

If Administrative Fees are based on tiers, check box ☐ and indicate rates above in section 18.

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. Member past service for clients previously covered by VSP will carry over and remain in force.

C. Any non-VSP-created information outlining coverage or plan details must be reviewed by VSP prior to distribution to members.

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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

Firm/Organization: City of Fort Lauderdale

Name: Rickelle Williams Title: City Manager

Signature:

BROKER / CONSULTANT

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

Legal Firm Name: FBMC Benefits Management, Inc.

Address: 3101 Sessions Rd Suite 200

City: Tallahassee | County: Leon | State: FL | ZIP: 32303

Licensed Producer's Name: Rick Farris | Title: Chief Growth Officer

Phone: 850-425-6200 | Fax: | E-mail: accounting@fbmc.com

Broker Assistant Name: | Phone: | E-mail:

Taxpayer ID: 59-1657263 | Corporation ☒ Independent ☐

Commission Checks Payable to:

☒ Firm Name

☐ Contact Name

☒ Commission rate if paid: 10% ☐ Not Paid

Name: FBMC Benefits Management, Inc.

Address: 3101 Sessions Rd., Suite 200

City: Tallahassee | County: Leon | State: Florida | ZIP: 32303

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

Print Name: Rick Ferris | Title: Chief Growth Officer

Signature of state-licensed agent:

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

ADDITIONAL BROKER / CONSULTANT

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

Legal Firm Name: Stealth Partner Group

Address: 18700 N Hayden Rd suite 405

City: Scottsdale | County: Maricopa | State: AZ | ZIP: 85255

Licensed Producer's Name: Jeremy Fife | Title: CEO

Phone: 214.453.1951 | Fax: N/A | E-mail: Jeremy.Fife@amwins.com

Broker Assistant Name: Beth Hays | Phone: 214.561.7061 | E-mail: beth.hays@amwins.com

Taxpayer ID: 13-4009411 | Corporation ☒ Independent ☐

Commission Checks Payable to:

☒ Firm Name

☐ Contact Name

☒ Commission rate if paid: 5% ☐ Not Paid

Name:

Address:

City: | County: | State: | ZIP:

This application signed this [5th] (day) of [September] (month) of [2025] (year).

Print Name: Jeremy Fife | Title: CEO

Signature of state-licensed agent: