VISION CARE DIRECT

By: Vision Care Plus

Employer Application Form

EMPLOYER		
ADDRESS		
CITY	STATE	ZIP
EMPLOYER (TAX) ID #	CONTACT PERSON	
PHONE	FAX	EMAIL
EFFECTIVE DATE	DATE OF 1ST DEDUCTION	RENEWAL DATE

PLAN AND RATE INFORMATION

☐ Standard Rates – Groups with less than 25 eligible lives

☐ Quoted Rates - **PLEASE ATTACH A COPY OF YOUR RATE QUOTE TO THIS FORM**

Plan(s) Selected (You may choose one or more plans):

Standard Plans:

☐ Gold ☐ Silver ☐ Bronze ☐ Materials Only ☐ Prescription Sunwear ☐ Eye, Health, Vision Exam Only

ComputerWear:

☐ Complete ☐ Materials Only

SafetyWear:

☐ Alpha –Complete ☐ Beta – Complete ☐ Delta – Complete ☐ Sigma – Complete ☐ Chi – Complete

☐ Alpha –Materials Only ☐ Beta – Materials Only ☐ Delta – Materials Only ☐ Sigma – Materials Only ☐ Chi – Materials Only

Rate Tier Selected (Choose one only, if applicable to your plan):

☐ 2-Tier

☐ 3-Tier

☐ 4-Tier

Monthly Rates:

Percent Paid By Employer: _________ %

Percent Paid By Employee: _________ %

Employee and Dependent Eligibility: Employees must be regularly scheduled at least ______ hours per week to be eligible for this plan.

Total Number of Employees: _________________

Coverage becomes effective for new employees (check one):

☐ On the first of the month following ______days of employment.

☐ Immediately following _______ days of employment.

Note: Employee and their dependents must wait for 45 days following effective date before seeking care to allow for administrative setup and notification of eligibility.

Coverage requirements for dependents:

Unmarried dependent children who have not attained their ______ birthday.

Full time students who have not attained their_______ birthday.

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EMPLOYER AGREEMENT:

We hereby agree to apply for membership in the Vision Care Direct Vision Plan (VCD), a vision benefit program owned by Vision Care Plus and administered by Vision Care Direct for the benefit of our employees. We will instruct the payroll department to honor the attached application requests signed by our employees to enroll themselves and/or their dependents in VCD, deduct the appropriate membership fee per family from the employee's earnings and forward to VCD Administration monthly such membership fees, as indicated on employer's monthly membership report and/or the monthly invoice.

It is agreed that this program will remain in effect for One Year for Gold, Materials Only, Rx Sunwear, ComputerWear Plans and/or Two Years for Silver and Bronze Plans, commencing from the Effective Date noted above and will automatically renew until terminated in writing by employer.

The Employer named above acknowledges and agrees that:

1. The employer will remit all monies due as specified herein and no later than five (5) days after the beginning of that month of coverage;
2. Failure to remit those monies by that date may result in automatic termination of participation of the Employer's employees and dependents in the Vision Care Direct Program (the "Program");
3. Payment by check does not constitute actual payment until the check is received by the administrator of the Program and honored by the drawee bank;
4. The Program will begin on _____________, 20____ and will end on____________, 20____ unless a renewal agreement is executed;
5. The employer has had the Program, including discounts and savings, explained in full to it and that it specifically understands that there is no insurance or rights shifted to Employer's employees under the Program; and
6. This Agreement is voidable by the Program if this Application contains any material misrepresentations.

I, the undersigned Employer, do hereby state that a full and complete explanation of the discounted fees and benefits has been given to me, and that I fully accept and subscribe to all the terms and conditions contained in this Agreement.

Employer assumes no responsibility as to the Plan after the termination of any employee.

Employer ____

Signature ____ Date ________________

Print Name ____ Title ________________

To be completed by Vision Care Plus Representative

VCP Representative

Signature ____ Date ________________

Print Name ____ Title ________________

Selling Agent or Broker of Agent of Record

Print Name ____________________________________ Agency ____________________

Address ______________________________________ Phone ____________________

General Agent

Print Name ____________________________________ Agency ____________________

Referring Doctor

Print Name ____________________________________ Practice ____________________

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