VISION CARE DIRECT

By: Vision Care Plus - Kansas

Individual Enrollment Form

To Enroll: Simply complete the enrollment form below and **Return To: Vision Care Direct at 2178 South 900 East, #4 Salt Lake City, Utah, 84106.** Enroll only family members for who membership is desired. You need not enroll all family members.

LAST NAME	FIRST NAME	MIDDLE

ADDRESS	CITY	STATE	ZIP

EMPLOYER/ GROUP

CHOOSE EFFECTIVE DATE	BIRTHDATE (MM/DD/YY)	SEX ☐M ☐F	SOCIAL SECURITY NO	OPTIONAL 9-DIGIT ID NO

WORK PHONE	HOME PHONE	EMAIL ADDRESS

MARITAL STATUS ☐SINGLE ☐MARRIED ☐DIVORCED ☐SEPARATED ☐WIDOWED

SPOUSE – LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE (MM/DD/YY)	SEX ☐M ☐F	
DEPENDENT– LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE (MM/DD/YY)	SEX ☐M ☐F	FULL –TIME STUDENT ☐Y ☐N
DEPENDENT– LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE (MM/DD/YY)	SEX ☐M ☐F	FULL –TIME STUDENT ☐Y ☐N
DEPENDENT– LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE (MM/DD/YY)	SEX ☐M ☐F	FULL –TIME STUDENT ☐Y ☐N
DEPENDENT– LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE (MM/DD/YY)	SEX ☐M ☐F	FULL –TIME STUDENT ☐Y ☐N

■ Annual Payment Option

Please mark your choice of plans, and method of payment

Complete:	☐ Single $ 190.00	☐ Family of Two $ 352.00	☐ Family of Three $ 544.00	☐ Family of Four +$ 714.00
Materials Only:	☐ Single $ 128.00	☐ Family of Two $ 238.00	☐ Family of Three $ 368.00	☐ Family of Four +$ 482.00
Exam Only:	☐ Single $ 61.00	☐ Family of Two $ 114.00	☐ Family of Three $ 176.00	☐ Family of Four +$ 231.00

☐ Check # ________________ **Credit Card Type:** ☐ Mastercard ☐ Visa ☐ Discover / Novus ☐ American Express

Credit Card Number: ____ Exp. Date ____ / _____ / _____

Cardholder's Name: ____ Daytime Phone: ________________________

Cardholder's Signature: ____ Date: ___ / _____ / _____

Make annual payment payable to Vision Care Direct. I authorize Vision Care Direct to process payment as specified above.
I understand that rates are subject to change upon renewal.

■ Monthly Bank Draft Option

Please mark your choice of plans and authorize Surepay Electronic Funds Transfer Payment

Complete:	☐ Single $ 16.22	☐ Family of Two $ 29.32	☐ Family of Three $ 44.88	☐ Family of Four + $ 58.60
Materials Only:	☐ Single $ 11.22	☐ Family of Two $ 20.07	☐ Family of Three $ 30.59	☐ Family of Four + $ 39.86
Exam Only:	☐ Single $ 5.80	☐ Family of Two $ 10.05	☐ Family of Three $ 15.10	☐ Family of Four + $ 19.65

Please charge my checking account monthly. I have enclosed a check for my **First Month's Payment of $ ___________ made payable to Vision Care Direct, plus a voided check from the account to be debited monthly.**

Bank Name: ________________________________ City: ___________________________ Account #: __________________

☐ Draft Authorization/Member Agreement: Unless I have elected Annual Payment by check or credit card, I hereby authorize Vision Care Direct to charge my account the application membership fee, to be credited to my account with Vision Care Direct. This authorization is to remain in full force and effect until I notify Vision Care Direct in writing of its termination. (My bank is authorized to make corrections if necessary). I have read and understand the terms of this authorization. I agree to maintain membership for a period of one year and to authorize monthly bank drafts during that year. Les than one year membership may result in being billed by the doctors at their usual and customary rate, minus membership fees paid. All membership fees are non refundable.

Authorized Signature: ____ Date:___ / _____ / _____

SIGNATURE AUTHORIZING ENROLLMENT IN VISION PLAN

Subscribers Signature: ____ Date:___ / _____ / _____

BROKER INFORMATION – VISION CARE DIRECT REPRESENTATIVE

Broker: _____________________________ Sales Rep: ______________________________ Date:___ / _____ / _____

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