



**To Enroll:** Simply complete the enrollment form below and return to Vision Care Direct.

**PLEASE PRINT LEGIBLY USING BLACK INK.**

LAST NAME			FIRST NAME			MIDDLE		
ADDRESS								
CITY			STATE			ZIP		
GROUP/ ORGANIZATION								
<p><b>You must check the plan in which you are enrolling:</b></p> <p><b>Standard Plans:</b></p> <input type="checkbox"/> Gold <input type="checkbox"/> Silver <input type="checkbox"/> Bronze <input type="checkbox"/> Materials Only <input type="checkbox"/> Prescription Sunwear <input type="checkbox"/> Eye, Health, Vision Exam Only <p><b>Coverage:</b>                      ___ 100    ___ 130    ___ 160    Benefit Level</p> <input type="checkbox"/> Employee <input type="checkbox"/> Employee +1 <input type="checkbox"/> Employee + Family <input type="checkbox"/> Declining Coverage at this time    Signature: _____    Date: _____								
ENROLLMENT DATE			<input type="checkbox"/> FULL TIME			<input type="checkbox"/> PART TIME		
BIRTHDATE (MM/DD/YY)			SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			SOCIAL SECURITY NUMBER		
WORK PHONE			HOME PHONE			EMAIL ADDRESS		
SPOUSE - LAST NAME			FIRST NAME			MIDDLE		
BIRTHDATE (MM/DD/YY)			SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE					
DEPENDENT - LAST NAME			FIRST NAME			MIDDLE		
BIRTHDATE (MM/DD/YY)			SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			FULL-TIME STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO		
DEPENDENT - LAST NAME			FIRST NAME			MIDDLE		
BIRTHDATE (MM/DD/YY)			SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			FULL-TIME STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO		
DEPENDENT - LAST NAME			FIRST NAME			MIDDLE		
BIRTHDATE (MM/DD/YY)			SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			FULL-TIME STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO		

Make all checks payable to Vision Care Direct and send checks to the Claims and Administration Office at 2178 South 900 East, #4, Salt Lake City, Utah 84106. All VCD contracts in Kansas are with the Vision Care Plus IPA (Independent Provider Association).

I authorize my employer to make payroll deductions of monthly contributions from my earnings. I commit to making all financial contributions required by this program over the period of the contract which is twelve months (12) for Gold, Materials Only, Rx Sunwear, ComputerWear, and SafetyWear Plans and 24 months (24) for Silver and Bronze Plans. Should I leave the employment under which I enrolled in the program, I have the opportunity to convert to a VCD Individual Plan. Should I agree to have my plan converted to an individual plan, I will be subject to the terms and conditions under that plan.

Enrollee Signature: \_\_\_\_\_ Date: \_\_\_\_\_