



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

PLEASE TYPE OR PRINT LEGIBLY USING BLACK INK.

LAST NAME			FIRST NAME			MIDDLE		
ADDRESS								
CITY			STATE			ZIP		
GROUP/ ORGANIZATION								
You must check the plan in which you are enrolling:								
<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								
Coverage:								
<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		

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 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. All VCD contracts in Arizona are with the Arizona Eyecare Alliance IPA (Independent Provider Association).

Enrollee Signature: _____ Date: _____