



VCD Voluntary ComputerWear Plan	Benefits
Eye, Health & Vision Care (exam includes refraction) With a \$15 member payment, exams are allowed once per 12 months	No charge
Lenses¹ With a \$15 materials (frame and/or lens) member payment, one pair of lenses allowed per 12 months . Standard Single Vision or Near Variable Focus lenses including Anti-reflective coating and Color filter.	No charge
Frames² One frame allowed every 12 months with a retail value of \$100	Up to plan limit²

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

LAST NAME			FIRST NAME			MIDDLE		
ADDRESS								
CITY			STATE			ZIP		
GROUP/ ORGANIZATION								
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		
Please check the plan you are enrolling in:								
<input type="checkbox"/> ComputerWear Complete <input type="checkbox"/> ComputerWear Materials Only								
RATES								
Monthly Payroll Deduct		Employee		Employee +1		Employee + family		
ComputerWear Complete		\$ 22.50		\$ 41.36		\$ 64.35		
ComputerWear Materials Only		\$ 18.00		\$ 33.30		\$ 51.48		
ENROLLING FAMILY MEMBERS – Complete portion below for additional members.								
SPOUSE - LAST NAME			FIRST NAME			MIDDLE		
BIRTHDATE (MM/DD/YY)			SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE					
DEPENDANT - 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		
DEPENDANT - 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 Arizona are with the Arizona Eyecare Alliance 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 ComputerWear 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: _____