



VISION CARE DIRECT

By: Arizona Eyecare Alliance

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 <input type="checkbox"/> M <input type="checkbox"/> F | SOCIAL SECURITY NO | | OPTIONAL 9-DIGIT ID NO |
| WORK PHONE | | | HOME PHONE | | | EMAIL ADDRESS | | |
| MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED | | | | | | | | |
| SPOUSE - LAST NAME | | FIRST NAME | | MIDDLE INITIAL | BIRTHDATE (MM/DD/YY) | | SEX <input type="checkbox"/> M <input type="checkbox"/> F | |
| DEPENDENT- LAST NAME | | FIRST NAME | | MIDDLE INITIAL | BIRTHDATE (MM/DD/YY) | | SEX <input type="checkbox"/> M <input type="checkbox"/> F | FULL -TIME <input type="checkbox"/> Y <input type="checkbox"/> N STUDENT |
| DEPENDENT- LAST NAME | | FIRST NAME | | MIDDLE INITIAL | BIRTHDATE (MM/DD/YY) | | SEX <input type="checkbox"/> M <input type="checkbox"/> F | FULL -TIME <input type="checkbox"/> Y <input type="checkbox"/> N STUDENT |
| DEPENDENT- LAST NAME | | FIRST NAME | | MIDDLE INITIAL | BIRTHDATE (MM/DD/YY) | | SEX <input type="checkbox"/> M <input type="checkbox"/> F | FULL -TIME <input type="checkbox"/> Y <input type="checkbox"/> N STUDENT |
| DEPENDENT- LAST NAME | | FIRST NAME | | MIDDLE INITIAL | BIRTHDATE (MM/DD/YY) | | SEX <input type="checkbox"/> M <input type="checkbox"/> F | FULL -TIME <input type="checkbox"/> Y <input type="checkbox"/> N STUDENT |

Annual Payment Option**Please mark your choice of plans, and method of payment**

Complete: Single \$ 168.00 Family of Two \$ 310.00 Family of Three \$ 479.00 Family of Four +\$ 629.00
 Materials Only: Single \$ 114.00 Family of Two \$ 210.00 Family of Three \$ 325.00 Family of Four +\$ 426.00
 Exam Only: Single \$ 54.00 Family of Two \$ 100.00 Family of Three \$ 155.00 Family of Four +\$ 203.00

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 \$ 14.36 Family of Two \$ 25.89 Family of Three \$ 39.59 Family of Four + \$ 51.66
 Materials Only: Single \$ 9.99 Family of Two \$ 17.80 Family of Three \$ 27.08 Family of Four + \$ 35.25
 Exam Only: Single \$ 5.18 Family of Two \$ 8.89 Family of Three \$ 13.31 Family of Four + \$ 17.21

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. Less 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: Don Rice & Associates, LLC Sales Rep: Jane Kassel Date: ____ / ____ / ____