



Individual Enrollment Form

To Enroll:

Simply complete the enrollment form below and **Return To: Vision Care Direct at 2178 South 900 East, #6 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 \$ 207.00 Family of Two \$ 382.00 Family of Three \$ 591.00 Family of Four + \$ 774.00
 Materials Only: Single \$ 150.00 Family of Two \$ 277.00 Family of Three \$ 429.00 Family of Four + \$ 562.00
 Exam Only: Single \$ 57.00 Family of Two \$ 105.00 Family of Three \$ 162.00 Family of Four + \$ 212.00
 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 \$ 17.50 Family of Two \$ 31.70 Family of Three \$ 48.58 Family of Four + \$ 63.46
 Materials Only: Single \$ 12.92 Family of Two \$ 23.22 Family of Three \$ 35.48 Family of Four + \$ 46.26
 Exam Only: Single \$ 5.38 Family of Two \$ 9.28 Family of Three \$ 13.90 Family of Four + \$ 17.98

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: _____ Mike Monson (535) _____ Sales Rep: _____ Sidney Gran (515) _____