VISION CARE DIRECT
The vision plan your eye doctor recommends™
By: Summit EyeCare Alliance Management Company, Inc.

Group Application Form

- This is a membership plan, not vision insurance.

GROUP		
STREET ADDRESS		
CITY	STATE	ZIP
MAILING ADDRESS *(If same as above, leave blank)*		
CITY	STATE	ZIP
GROUP (TAX) ID #	CONTACT PERSON	
PHONE	FAX	EMAIL
EFFECTIVE DATE	DATE OF 1ST DEDUCTION	RENEWAL DATE

Please attach the accepted rate sheet to this form. All plans will assumed to be offered unless indicated below.

If limiting plan choices, the following will be the only plans offered to our employees :

Complete plans: Plan name(s): _____

☐ $100 frame allowance ☐ $130 frame allowance ☐ $160 frame allowance ☐ $200 frame allowance

A la carte options:

Exam Only Plan:	☐ Healthy Eye Exam Benefit			
Platinum Materials Only:	☐ $100 frame allowance	☐ $130 frame allowance	☐ $160 frame allowance	☐ $200 frame allowance
Gold Materials Only:	☐ $100 frame allowance	☐ $130 frame allowance	☐ $160 frame allowance	☐ $200 frame allowance
Rx Sunwear:	☐ $100 frame allowance	☐ $130 frame allowance	☐ $160 frame allowance	☐ $200 frame allowance

Other Plan ***(i.e. ComputerWear, VCD Gunnar):*** _____

Rate Tier Selected (Choose one only, if applicable to your plan):

☐ 2-Tier ☐ 3-Tier ☐ 4-Tier

Group Contribution: Percent Paid By Group: _____ % Percent Paid By Member: _____ %

Member and Dependent Eligibility: Members must be regularly scheduled at least _____ hours per week to be eligible for this plan.

Total Number of Eligible Members: _____

Membership becomes effective for new members (check one):

☐ On the first of the month following _____days of employment.

☐ Immediately following _____ days of employment.

Membership requirements for dependents:

Unmarried dependent children who have not attained their _____ birthday.

Full time students who have not attained their_____ birthday.

National Sales & Administration Office ▪ 2178 South 900 East #7, Salt Lake City, UT 84106 ▪ Toll Free: (877) 488-8900 Fax: (801) 466-4113

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GROUP AGREEMENT:

We hereby agree to apply for membership in the Vision Care Direct Vision Plan (VCD), a vision benefit program owned by Summit EyeCare Alliance Management Company, Inc. and administered by Vision Care Direct for the benefit of our members. We will instruct the payroll department to honor the attached application requests signed by our members to enroll themselves and/or their dependents in VCD, deduct the appropriate membership fee per family from the member's earnings and forward to VCD Administration monthly such membership fees, as indicated on group's monthly membership report and/or the monthly invoice.

It is agreed that this program will remain in effective for One Year for programs with a maximum 12 month benefit and/or Two Years for programs with a maximum 24 month benefit commencing from the Effective Date noted above and will automatically renew until terminated in writing by group. To determine maximum benefit period, refer to Plan Summary document provided with rate proposal.

The Group named above acknowledges and agrees that:

1. The group will remit all monies due as specified herein and no later than five (5) days after the beginning of that month of membership;
2. Failure to remit those monies by that date may result in automatic termination of participation of the Group's members and dependents in the Vision Care Direct Program (the "Program");
3. Payment by check does not constitute actual payment until the check is received by the administrator of the Program and honored by the drawee bank;
4. The Program will begin on _____, 20____ and will end on_____, 20____ unless a renewal agreement is executed;
5. The group has had the Program, including savings, explained in full to it and that it specifically understands that there is no insurance or rights shifted to Group's members under the Program; and
6. This Agreement is voidable by the Program if this Application contains any material misrepresentations.
7. If legal action is necessary to collect any monies due, Group shall pay all costs of collection, including attorneys' fees. Jurisdiction and venue for all legal actions shall be the State of Pennsylvania and Pennsylvania law shall govern.

I, the undersigned Group, do hereby state that a full and complete explanation of the savings and benefits of membership has been given to me, and that I fully accept and subscribe to all the terms and conditions contained in this Agreement.

Group assumes no responsibility as to the Plan after the termination of any member.

Group _____

Signature _____ Date _____

Print Name _____ Title _____

To be completed by Summit EyeCare Alliance Management Company, Inc. Representative

IPA Representative

Signature _____ Date _____ Agent # _____

Print Name _____ Title _____

Selling Agent or Broker of Agent of Record

Print Name _____ Agency _____ Agent # _____

Address _____ Phone _____

General Agent

Print Name _____ Agency _____ Agent # _____

Referring Doctor

Print Name _____ Practice Name _____

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