VISION CARE DIRECT
The vision plan your eye doctor recommends™

Member Application Form - PK

- **To Enroll:** Simply complete the form below and return to Vision Care Direct.
- This is a membership plan, not vision insurance

☐ **CHANGES TO EXISTING PLAN**

GROUP/ ORGANIZATION	GROUP/ORGANIZATION LOCATION	REQUESTED EFFECTIVE DATE	EMPLOYMENT STATUS ☐ FULL TIME ☐ PART TIME
LAST NAME	FIRST NAME	MIDDLE	
ADDRESS			
CITY	STATE	ZIP	
BIRTHDATE (MM/DD/YY)	SEX ☐ MALE ☐ FEMALE	HOME PHONE	WORK PHONE
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED		EMAIL ADDRESS	

☐ **I am declining enrollment at this time.** Signature: ______________________________

You must check the plan in which you are enrolling – you may enroll in more than one plan

1. Select number of plan/s you are enrolling in: ☐ I am enrolling in ONE plan ☐ I am enrolling in MULTIPLE plans

2. Select your Plan/s (you may select one or more):

- ☐ **Platinum Complete 200 PK**
- ☐ **Gold Complete 200 PK**
- ☐ **Exam Only Plan**
- ☐ **Platinum Materials Only 200 PK**
- ☐ **Gold Materials Only 200 PK**

DEPENDENTS TO ENROLL:

	FIRST NAME	MIDDLE	BIRTHDATE (MM/DD/YY)	
SPOUSE - LAST NAME	FIRST NAME	MIDDLE	BIRTHDATE (MM/DD/YY)	☐ MALE ☐ FEMALE
CHILD - LAST NAME	FIRST NAME	MIDDLE	BIRTHDATE (MM/DD/YY)	☐ MALE ☐ FEMALE
CHILD - LAST NAME	FIRST NAME	MIDDLE	BIRTHDATE (MM/DD/YY)	☐ MALE ☐ FEMALE
CHILD - LAST NAME	FIRST NAME	MIDDLE	BIRTHDATE (MM/DD/YY)	☐ MALE ☐ FEMALE
CHILD - LAST NAME	FIRST NAME	MIDDLE	BIRTHDATE (MM/DD/YY)	☐ MALE ☐ FEMALE
CHILD - LAST NAME	FIRST NAME	MIDDLE	BIRTHDATE (MM/DD/YY)	☐ MALE ☐ FEMALE
CHILD - LAST NAME	FIRST NAME	MIDDLE	BIRTHDATE (MM/DD/YY)	☐ MALE ☐ FEMALE

Note: Membership cards are automatically generated when the Member Application Form is processed and entered into the Vision Care Direct system. Please wait until you receive your membership card to seek care. If you require care before your card arrives, please have your VCD doctor log-on to www.VisionCareDirect.Com to verify eligibility.

I understand that Vision Care Direct is a membership plan and not vision insurance.

I understand I may make changes for a Qualifying Event (see company policy).

I authorize my group to make payroll deductions of monthly contributions from my earnings. As long as I remain employed at my current group, I commit to making all financial contributions required by this program over the period of the contract which is twelve (12) months for all Platinum PK, Gold PK and Exam Only Plans. Should I leave the group 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: ____________________

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