Vision Enrollment Form
Hillsborough County Retiree
CONTRIBUTION RATES:

Humana®

ANNUALLY
Visa/Mastercard
Check or M.O.

Retiree:	$51.12
Retiree + One:	$150.96
Retiree +Family:	$201.96

BANK DRAFT:
ANNUALLY
Visa/Mastercard
Check or M.O.

ACT NOW.

Simply complete and mail the attached enrollment form. This is your first step to maintaining good Visual health with CompBenefits VisionCare Plan.

ENROLLMENT INSTRUCTIONS:

1. Complete the enrollment form. (Be sure to list all Family Members to be included.)
2. Select your payment mode.
   Choose Visa or MasterCard.
   Fill out Bank Card Section and send no money, or enclose your check for the full annual premium.
3. Make check payable to CompBenefits Company and mail all documents to:
   Compbenefits Dental Vision
   P.O. Box 769649
   Roswell, GA 30076-8225

   Completed enrollment forms, with correct premiums, received by Home Office by the 15th of the month will become effective on the 1st of the following month.

Group Name: **Hillsborough County Retiree**

Social Security No.	Last Name	First	MI	Date Of Birth / /
Home Address		Home Phone ( )		Sex M☐ F☐
City	State	Zip Code	Business Phone	
			( )	

List All Your Eligible Dependents If They Are To Be Covered

	First	Middle	Last	Sex	Birthdate
2. Spouse:				M☐ F☐	/ /
3. Child:				M☐ F☐	/ /
4. Child:				M☐ F☐	/ /
5. Child:				M☐ F☐	/ /

Requested Effective Date		
# Dependents Covered	Plan Code Annually: VCP555-1	Premium Amount $
		Amount Paid $

I wish to enroll in the VisionCare Plan. I hereby authorize the deductions as indicated on the Authorization for Deduction for 12 months, and for future renewal period(s). I understand that enrollments are by group contract and/or for consecutive 12 month periods and my subscriber rates are subject to change on the anniversary date of the group. I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Signature: **X** _____ Date: _____

BANK CARD SELECTION
For Your Convenience:

MasterCard ☐ Visa ☐ FILL IN CARD NUMBER Expiration Date MO. YR.

AMOUNT CHARGED

ANNUAL CONTRIBUTION **$** _____ I hereby authorize charging my Bank Card.

CARDHOLDER'S
SIGNATURE **X** _____ DATE _____

HOME OFFICE USE

TRANSIT NUMBER _____ C.U. NBR. _____ ACCOUNT NUMBER _____

DATE DRAFT 15 _____ BUYER'S NAME _____

TO: THE EMPLOYER, FINANCIAL, OR OTHER ORGANIZATION NAMED ON THE REVERSE SIDE.

In consideration of your paying checks and drafts drawn or purported to be drawn by the undersigned on the checking account of any of your depositors, undersigned hereby agrees that:

(1) It will indemnify you against and hold you harmless from any and all liability, loss, damage and expense which may be incurred by you because of your payment or dishonor of any such checks so drawn or purported to be drawn whether the payment or dishonor was intentional or through nadvertence, and will further indemnify and hold you harmless from any liability to any persons making claims under any Agreement with respect to which checks are drawn. We will refund you any amount erroneously paid by you on any such check;

(2) It will refund to you any amount erroneously paid by you to undersigned on any such check if claim is made therefore by you within 3 months from the date of payment; and

(3) Either you or undersigned my terminate this agreement by ten (10) days prior written notice by either to the other or the agreement will be immediately terminated on the closing of the depositor's account or by the revocation by the depositor of authorization, but any such termination shall not affect undersigned's obligations and liabilities hereunder with respect to any such checks or dishonored by you prior to termination.

CompBenefits Company

President: _____
Signature