CompBenefits Insurance Company
VisionCare Plan
3-Tier Enrollment Card

VisionCare Plan — CompBenefits Insurance Company

VisionCare Plan Enrollment Card (Please print or type) — Effective date of coverage: ____/ ____ / ____

Group Number:_____

Sponsoring Organization: International Association of Fire Fighters Local 73

_____ Social Security # ____/ ____/ ____
Last Name First Name MI

_____ Date of birth: ____/ ____/ ____
Address City State Zip

Sex: ☐ F ☐ M Marital Status: ☐ Single ☐ Married

Your Family: Are you enrolling dependents in the VisionCare Plan? ☐ Yes ☐ No

Please list the full name, sex, and date of birth of each family member to be covered by this plan:

	Last Name	First Name	MI	Sex	Date of Birth (mo/day/year)
Your Spouse:				☐F ☐M	___/ ___/ ___
Your Child(ren):				☐F ☐M	___/ ___/ ___
				☐F ☐M	___/ ___/ ___
				☐ F ☐M	___/ ___/ ___
				☐ F ☐M	___/ ___/ ___

I authorize Local 73 to facilitate payroll and retirement plan deductions (per pay period or per month) for:

☐ Employee Only: $ _____ or ☐ Employee + One: $ _____ or ☐ Employee + Family: $ _____

I agree to stay in the VisionCare Plan for the entire enrollment period, assuming I stay affiliated with this organization. I understand that future rates for 12-month renewals of this plan will be negotiated between my organization and CompBenefits Insurance Company. I hereby consent, personally and on behalf of any family members enrolled, to the unrestricted release of my/our vision records maintained by participating providers to CompBenefits Insurance Company for, but not limited to, claims verification and quality assessment review, and to any other participating providers who may be or become involved in my/our vision care.

Date: _____ Signed:_____

PLEASE NOTE: Any person who knowingly, with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

HOW TO ENROLL

1.) Complete the enrollment application above.

2.) Return the application along with your check for the first full monthly premium payable to **LOCAL 73 DENTAL PLAN**. Please mail to Lee Stertz, MCRT Benefits Plus, 230 S. Bemiston, Ste. 900, Clayton, MO 63105.

3.) Upon receipt of your application by CompBenefits, you will be sent an ID card and information regarding your vision services.

Current Rates:
Employee Only – $6.90
Employee + One – $13.78
Employee + Family - $18.44