

# CompBenefits Insurance Company

## Vision Care, Inc.

### Florida 3-Tier Enrollment Card

Vision Care, Inc.	CompBenefits Insurance Company																														
Vision Plan Enrollment Card (Please print or type)	Effective date of coverage: ____/____/____																														
	Date of employment: ____/____/____																														
Employer: _____ Division: _____ Group #: _____																															
<table style="width: 100%; border: none;"> <tr> <td style="width: 60%;">You _____</td> <td style="width: 40%;">Social Security # ____/____/____</td> </tr> <tr> <td style="text-align: center;">Last Name                      First Name                      MI</td> <td></td> </tr> <tr> <td colspan="2" style="padding: 5px;">_____</td> </tr> <tr> <td style="text-align: center;">Address                      City                      State                      Zip</td> <td style="padding: 5px;">Date of Birth: ____/____/____</td> </tr> <tr> <td></td> <td style="padding: 5px;">Sex: <input type="checkbox"/> F <input type="checkbox"/> M                      Status: <input type="checkbox"/> Single <input type="checkbox"/> Married</td> </tr> </table>		You _____	Social Security # ____/____/____	Last Name                      First Name                      MI		_____		Address                      City                      State                      Zip	Date of Birth: ____/____/____		Sex: <input type="checkbox"/> F <input type="checkbox"/> M                      Status: <input type="checkbox"/> Single <input type="checkbox"/> Married																				
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<p>Your Family:      Are you enrolling dependents in the VisionCare Plan?                      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>                          Are the same dependents covered under your employee medical Plan?                      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>                          Please list the full name, sex, and date of birth of each family member to be covered by this plan:</p> <table style="width: 100%; border: none;"> <thead> <tr> <th style="width: 15%;"></th> <th style="width: 25%;">Last Name</th> <th style="width: 25%;">First Name</th> <th style="width: 5%;">MI</th> <th style="width: 10%;">Sex</th> <th style="width: 20%;">Date of Birth (mo/day/year)</th> </tr> </thead> <tbody> <tr> <td>Your Spouse:</td> <td>_____</td> <td>_____</td> <td>_____</td> <td><input type="checkbox"/> F <input type="checkbox"/> M</td> <td>____/____/____</td> </tr> <tr> <td>Your child(ren):</td> <td>_____</td> <td>_____</td> <td>_____</td> <td><input type="checkbox"/> F <input type="checkbox"/> M</td> <td>____/____/____</td> </tr> <tr> <td></td> <td>_____</td> <td>_____</td> <td>_____</td> <td><input type="checkbox"/> F <input type="checkbox"/> M</td> <td>____/____/____</td> </tr> <tr> <td></td> <td>_____</td> <td>_____</td> <td>_____</td> <td><input type="checkbox"/> F <input type="checkbox"/> M</td> <td>____/____/____</td> </tr> </tbody> </table>			Last Name	First Name	MI	Sex	Date of Birth (mo/day/year)	Your Spouse:	_____	_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	____/____/____	Your child(ren):	_____	_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	____/____/____		_____	_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	____/____/____		_____	_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	____/____/____
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<p>I authorize VisionCare Plan payroll deductions (per month or per pay period) for:</p> <p><input type="checkbox"/> Employee Only: \$ _____ or <input type="checkbox"/> Employee + One: \$ _____ or <input type="checkbox"/> Employee + Family: \$ _____</p> <p>I agree to stay in the VisionCare Plan for the entire enrollment period, assuming I stay employed with this employer. I understand that future rates for 12-month renewals of this plan will be negotiated between my employer 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.</p> <p>Date: _____ Signed: _____</p> <p>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.</p>																															