CompBenefits Insurance Company
Vision Care, Inc.
Florida 2-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 #: _____

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

_____ Date of Birth: _____/_____/_____
Address City State Zip

Sex: ❑ F ❑ M Status: ❑ Single ❑ Married

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

Are the same dependents covered under your employee medical 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	____/____/____

I authorize VisionCare Plan payroll deductions (per month or per pay period) for:

❑ Employee Only: $_____ or ❑ Employee + Family: $_____

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.

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.