Broker Member Enrollment Form

Use this enrollment form as a guide to gathering your client's information. **Important:** in order to receive commissions you still need to enroll clients on their behalf online using your marketing link.

VSP® Individual Vision Care

State of Residence:_____

Coverage Type (select one):

	Base Plan			EasyOptions Plan (unavailable in FL)		
	One-person Plan	Two-person Plan	Family Plan	One-person Plan	Two-person Plan	Family Plan
Annual Pay	○	○	○	○	○	○
Monthly Pay 12 payments required	○	○	○	○	○	○

When would you like your membership to start?

(Must allow one week from submission for processing)

○ First of this month ○ First of next month

Member Information

First Name: _____ **Last Name:** _____

Mailing Address:_____

City: _____ **State:** _____ **Zip:**_____

Primary Phone: _____

Date of Birth (dd/mm/yy):_____

Gender: ○ Male ○ Female

Marital Status: ○ Married ○ Single ○ Divorced

Ethnicity:

○ American Indian or Alaska Native
○ Black or African American
○ Hispanic or Latino
○ Native Hawaiian or other Pacific Islander
○ Asian
○ White (non Hispanic)
○ Prefer not to disclose
○ Other (please specify)

Valid e-mail address to receive payment confirmation and member guide:

_____

Are you interested in receiving future offers for other products or services from Careington (VSP's third party administrator)? ○ Yes ○ No

Billing Information

Billing address—only if different from address above:

First Name:_____ **Last Name:** _____

Mailing Address:_____

City: _____ **State:** _____ **Zip:**_____

○ **I have read and agree to the attached Terms & Conditions.**

Payment Method (select one):

○ **CREDIT OR DEBIT CARD**

Name On Credit Card:

_____

Credit Card Type:

○ Visa
○ MasterCard
○ American Express
○ Discover

Credit Card Number:

_____

Expiration Date:_____

○ **BANK OR ELECTRONIC DRAFT**

Name On Account:

_____

Bank Name:

_____

9 digit ABA code/Routing Number:

_____

Account Number:

_____

Account Type (circle one)

○ Checking ○ Savings

Add Dependents

VSP® Individual Vision Care

Dependent 1

First Name: _____ **Last Name:** _____

Relation: ○ Spouse/Domestic Partner ○ Child **Date of Birth (dd/mm/yy):** _____

Full-time Student? ○ Yes ○ No **Developmentally Disabled:** ○ Yes ○ No

Dependent 2

First Name: _____ **Last Name:** _____

Relation: ○ Spouse/Domestic Partner ○ Child **Date of Birth (dd/mm/yy):** _____

Full-time Student? ○ Yes ○ No **Developmentally Disabled:** ○ Yes ○ No

Dependent 3

First Name: _____ **Last Name:** _____

Relation: ○ Spouse/Domestic Partner ○ Child **Date of Birth (dd/mm/yy):** _____

Full-time Student? ○ Yes ○ No **Developmentally Disabled:** ○ Yes ○ No

Dependent 4

First Name: _____ **Last Name:** _____

Relation: ○ Spouse/Domestic Partner ○ Child **Date of Birth (dd/mm/yy):** _____

Full-time Student? ○ Yes ○ No **Developmentally Disabled:** ○ Yes ○ No

Dependent 5

First Name: _____ **Last Name:** _____

Relation: ○ Spouse/Domestic Partner ○ Child **Date of Birth (dd/mm/yy):** _____

Full-time Student? ○ Yes ○ No **Developmentally Disabled:** ○ Yes ○ No

Dependent 6

First Name: _____ **Last Name:** _____

Relation: ○ Spouse/Domestic Partner ○ Child **Date of Birth (dd/mm/yy):** _____

Full-time Student? ○ Yes ○ No **Developmentally Disabled:** ○ Yes ○ No

Terms & Conditions

By enrolling in VSP's Individual Vision Care Policy, you indicate you have read the following terms and conditions of the plan.

This policy provides vision benefits only

Careington International Corp. ("Careington") provides customer service, billing services, and fulfillment services for this VSP product offering.

Monthly Payment Option: If you selected the monthly payment option for the annual benefit term, you agreed to pay the required annual premium in twelve (12) payments. The first payment will be withdrawn from your credit card or checking account at the time of enrollment and the remainder eleven (11) payments will be withdrawn on or around the 15th of each month. If you enroll between the 15th and last day of the month and choose to expedite your enrollment by selecting the current month effective date, you will be charged for current month and the following month at time of enrollment. If payment is not received for any reason, VSP may cancel your coverage after 30 days from when your premium was due. You are responsible to update your payment information by calling Member Services at 800-785-0699.

Renewal: This Policy is renewable at the option of the Policyholder and will automatically renew so long as premiums are paid in a timely manner, the Policyholder has not performed an act or practice that constitutes fraud and VSP continues to offer this plan. VSP will not cancel coverage under the Policy because of a Covered Person's health status requirements for vision care services. You will be notified on or around sixty (60) days prior to your auto-renewal. To make changes to your current plan, call Member Services at 800-785-0699 prior to your policy renewal date. If payment is not received for any reason, VSP may cancel your plan after thirty (30) days from when your premium was due.

Right to Return the Policy: You are permitted to return the Policy within thirty (30) days of its delivery to you and have the premium paid refunded, less the processing fee, if after examination of the Policy you are not satisfied with it for any reason. Please note that $25 of the annual fee is a non-refundable processing fee in states where allowed by law. If you return the Policy to VSP at its home office it shall be void from the beginning. This means that you will be responsible for payment in full of any services received or materials purchased from the Policy effective date to the date the Policy is voided. You must submit a written cancellation request to Member Services at **application@vspdirectpayment.com**, or **P.O. Box 2568, Frisco, TX 75034**, or fax to **888-335-7330**.

Other Insurance Coverage: VSP cannot coordinate plan benefits payable under this Policy with any other private or government insurance plan, including any other plan underwritten by VSP.

Grace Period: Unless, not less than thirty (30) days prior to the premium due date VSP has delivered to the Policyholder, or has mailed to the Policyholder's last address as shown by VSP's records, written notice of its intention not to renew this Policy beyond the period for which the premium has been accepted, a grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium.

Limitations, Exclusions & Exceptions: Some brands of spectacle frames and lenses may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Preferred Provider or by calling VSP's Customer Care Division at **800-877-7195.** Copayments and other out-of-pocket expenses apply to the eye examination and/or to the purchase of most materials. Services or materials of a cosmetic nature are not covered under this policy. Medical services and supplies are not covered under this policy. Each person covered under this policy will have higher out of pocket expenses if they use a doctor who is not part of VSP's provider network.

Healthy Vision Association
Membership in the Healthy Vision Association gives you access to enroll in an individual vision insurance plan from VSP Vision Care and other discount programs on goods, services and information. Visit **healthyvisionassociation.com** for details on the discount programs. Membership in Healthy Vision Association is available in all states, however, the Association does not have individual vision insurance policies available in Florida, New York, Oregon, or Washington.

If you elect to purchase the dental discount plan, the following terms and conditions apply.

This Dental Discount Plan is a discount membership program. Careington is not a licensed insurer, health maintenance organization, or other underwriter of health care services. No portion of any dental provider's fees will be reimbursed or otherwise paid by Careington. Careington is not licensed to provide and does not provide medical services or items to individuals. You will receive discounts for services at certain health care providers who have contracted with the plan. You are obligated to pay for all health care services at the time of service. Savings are based upon the dental provider's normal fees. Actual savings will vary depending upon location and specific services or products purchased. You are responsible to verify such services with each individual dental provider. The plan's discounts may not be used in conjunction with any other discount plan or program. All listed or quoted prices are current prices by participating dental providers and subject to change without notice. Any procedures performed by a non-participating dental provider are not discounted. From time to time, certain dental providers may offer products or services to the general public at prices lower than the discounted prices available through this Dental Discount Plan. In such event, members will be charged the lowest price. Discounts on professional services are not available where prohibited by law. This plan does not discount all dental procedures. Dental providers are subject to change without notice and services may vary in some states. It is the member's responsibility to verify that the dental provider participates in the plan. At any time Careington may substitute a provider network at its sole discretion. Careington cannot guarantee the continued participation of any dental provider. If the dental provider leaves the plan, you will need to select another dental provider. Dental providers contracted by Careington are solely responsible for the professional advice and treatment rendered to members and Careington disclaims any liability with respect to such matters.

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