VISION BENEFITS OF AMERICA **VBA#**
ENROLLMENT FORM

COVERAGE EFFECTIVE DATE _____/_____/_____

INSTRUCTIONS FOR EMPLOYEE:
1. COMPLETE SECTION BELOW AND SIGN.
2. RETURN COMPLETED FORM TO YOUR BENEFITS OFFICE.

EMPLOYEE SOCIAL SECURITY NUMBER _____

EMPLOYEE NAME_____ BIRTHDATE ____|_____|_____

ADDRESS _____

CITY _____ STATE_____ZIP CODE _____-_____

PLEASE LIST ALL FAMILY MEMBERS TO BE COVERED:

	FIRST NAME	MIDDLE INITIAL	LAST NAME	BIRTHDATE
SPOUSE				
CHILD				
CHILD				
CHILD				
CHILD				

STUDENT INFORMATION (COMPLETE FOR DEPENDENTS WHO ARE ENROLLED AS FULL-TIME COLLEGE STUDENTS.)

STUDENTS NAME	NAME OF SCHOOL OR UNIVERSITY	

ANY HANDICAPPED CHILD COVERED ON MEDICAL?

CHILD NAME _____ |_____|_____

EMPLOYEE SIGNATURE _____ DATE _____/_____/_____

PATTERSON AUTO WRECKING

Number of Employees: 22

MANAGED VISION CARE PROGRAM 1

Plan C Zero Copayment Program - Optional Dependent Coverage

FREQUENCY OF SERVICE:	Employee	Spouse	DEPENDENT AGE: to 26 Children
Vision Exam	12 Months	12 Months	12 Months
Lenses	12 Months	12 Months	12 Months
Frames	24 Months	24 Months	24 Months

BENEFITS:	EMPLOYEE CAN SELECT EITHER: VBA Participating Doctor (15,000 Nationwide) Amount Covered	OR	Non-Participating Doctor Amount Reimbursed
Vision Exam *(For glasses)*	100%		$ 40.00
Clear Standard Lenses *(Pair)*:			
Single Vision	100%		$ 40.00
Bifocal	100%		60.00
Blended No Line Bifocals	100%		60.00
Trifocal	100%		80.00
Progressives****	Controlled Costs		80.00
Lenticular	100%		120.00
Polycarbonate Lens Material***	100%		0.00
1 Year Scratch Protection	100%		0.00
Frame	100%*		$ 50.00
- OR -			
Contacts *(Selected in lieu of all eyeglass benefits listed above)*****			
Cosmetic	$160.00		$160.00
Medically Required	UCR**		320.00
Low Vision Aids *(Per 24 months)*	UCR**		$650.00

* Within the program's $50 wholesale allowance *(approximately $125 to $150 retail)*.

** Usual, Customary and Reasonable as determined by VBA.

*** Available In-Network at no charge for children under age 19.

**** Progressive Lenses typically retail from $150 to $400, depending on lens options. VBA's controlled costs generally range from $45 to $175.

***** The contact allowance is applied to all services/materials associated with contact lenses. This includes, but not limited to, contact exam, fitting, dispensing, cost of lenses, etc. No guarantee the contact allowance will cover entire contact lenses costs (services/materials).

COST PER EMPLOYEE PER MONTH: Rates are guaranteed for the full 2 years of the contract, and assume that the Company will pay the premium of all eligible employees. The employee, however, may choose to cover his or her dependents by paying the difference between the Employee Only rate and the Family rate. Once dependent coverage is selected, contributions must be maintained throughout the 24 month contract period.

ADD DEPENDENTS FOR
$10.00 MONTH