Opticare of Utah
1901 West Parkway Blvd., Salt Lake, City, UT 84119

APPLICATION FOR INDIVIDUAL VISION CARE INSURANCE POLICY

Please print all answers.

1. Owner (Applicant) – Owner is the Primary Insured			
(a) Owner Name (First/Middle/Last):			(b) Sex: □ Male □ Female
(c) Date of Birth (Mo./Day/Yr):	(d) Marital Status: □ Married □ Single □ Divorced □ Widowed		(e) Social Security Number
(f) Home Address (Street, City, State, Zip Code):		(g) E-mail Address: (optional)	(h) Home Phone Number

2. Dependents (Indicate the names of all dependents to be insured under the policy.)			
Name	**Date of Birth**	**Name**	**Date of Birth**
Spouse:		Child:	
Child:		Child:	
Child:		Child:	

3. Benefit Selection	
Vision Plan Selected	

4. Premium Payment		
Premium Payment Mode [ ] Monthly [ ] Quarterly [ ] Annually		**Amount of Premium Payment Enclosed** **$**
Payment Choice (Select one) [ ] Checking Account (enclose voided check) [ ] Savings Account [ ] Credit Card	**Account Number**	**Expiration Date of Credit Card**
Financial Institution Name:		

4. Representations - Owner Agreement

I agree that: (1) the statements and answers given in this application are true, complete, and correctly recorded to the best of my knowledge and belief; (2) this application will be part of the contract for which I apply; (3) the policy is a one year contract that is guaranteed renewable in accordance with the terms of the policy; (4) I understand that this policy must remain in force for a 12-month period and that premiums are due for the entire 12-month period; (5) I understand that this policy will be renewed on each policy anniversary date for a new 12-month period, unless give written notification to Opticare of Utah to terminate the policy 60 days prior to the policy renewal date. I will notify the Insurer if any statements or answers given in this application change prior to policy delivery; and (5) I have received the Outline of Coverage.

I hereby authorize Opticare of Utah to withdraw premium payments from the financial institution and account named above under Section 4 of this application. I understand that this authorization will remain in effect until the financial institution has received and has had reasonable time to act on a written request from me to terminate this agreement. I understand that I can stop a withdrawal by notifying the financial institution at least three business days before the withdrawal is made. In the event of a withdrawal error, I must promptly notify the financial institution to preserve any rights I may have. I understand that I may direct my billing inquiries to Opticare of Utah, 1901 W. Parkway Blvd., Salt Lake City, UT 84119.

No licensed insurance agent is authorized to: (a) make or modify contracts; (b) waive any Insurer rights or requirements; and (c) waive any information the Insurer requests.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison

The policy provides vision benefits only. Review your policy carefully.

Signature of Owner (Primary Insured)

Date signed

State in which Policy will be Delivered

State in which Owner Signed Application

Printed Name of Licensed Insurance Agent

Signature of Licensed Insurance Agent

Agent License Number