

Your vision. Our passion.



Where will your eyes take you today?

Whether it's a day in the life or a day to remember, you'll get the personalized eyecare you deserve with VSP. We help millions of people see well, stay healthy and fulfill their potential.

Value, choice, doctors.

Enrolling in VSP is an easy way to make your life a little better. Here's a snapshot of what you'll enjoy:

- affordable benefits with great savings
- a WellVision ExamSM focused on your health
- plenty of eyewear choices you'll love
- VSP doctors nearby with flexible schedules that work for you

Satisfaction?
You bet. You'll be 100% happy or we'll make it right.

Still not decided?

Find doctors in your neighborhood at vsp.com or call us at 800-877-7195. We'd love to talk with you. Once you're signed up, your great benefits are a snap to use.

Enroll today. You'll be glad you did.



Benefits Association, Inc. and VSP provide you with an affordable eyecare plan. Sign up for VSP today.

Your Coverage from a VSP Doctor

WellVision Exam[®] focuses on your eye health and overall wellness

- \$15 copay..... **every 12 months**

Prescription Glasses

- \$25 copay

Lenses..... **every 12 months**

- Single vision, lined bifocal, and lined trifocal lenses
- Polycarbonate lenses for dependent children

Frame..... **every 24 months**

- \$130 allowance for frame of your choice
- 20% off the amount over your allowance

~OR~

Contact Lens Care

- **No copay** **every 12 months**

\$130 allowance for contacts and the contact lens exam (fitting and evaluation). This additional exam ensures proper fit of contacts. If you choose contact lenses you will be eligible for a frame 12 months from the date the contact lenses were obtained.

Current soft contact lens wearers may qualify for a special program that includes a contact lens evaluation and initial supply of replacement lenses.

Extra Discounts and Savings

Glasses and Sunglasses

- 20% off lens options like progressives and scratch-resistant and anti-reflective coatings
- 20% off additional glasses and sunglasses, including lens options*

Contacts*

- 15% off cost of contact lens exam (fitting and evaluation)

Laser Vision Correction

- Average 15% off the regular price or 5% off the promotional price from contracted facilities

* Available from any VSP doctor within 12 months of your last eye exam

Monthly Rates

Member Only.....	\$13.86
Member + One Dependent.....	\$23.34
Member + Family.....	\$35.73

You get the best value from your benefit when you see a VSP doctor. If you see a non-VSP provider, you'll typically pay more out-of-pocket. You'll pay the provider in full and have 6 months to submit a claim to VSP for partial reimbursement less copays. Before seeing a non-VSP provider, call us at 800.877.7195.

Out-of-Network Reimbursement Amounts:

Exam.....	Up to \$34
Single vision lenses.....	Up to \$17
Lined bifocal lenses.....	Up to \$30
Lined trifocal lenses.....	Up to \$43
Frame.....	Up to \$38.25
Contacts.....	Up to \$100

VSP guarantees service from VSP doctors only. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.



Employee Benefit Brokers

There will be a one time non-refundable \$35.00 setup fee.



VSP Individual Vision Enrollment Form

Type of Coverage: Member Member + 1 Member + Family

Method of Payment

Primary Enrollee:				Please select your preferred method of Payment from the choices below. All payments will be drafted from your checking account or charged to your credit card between the 1 st and 5 th of each month. <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually <input type="checkbox"/> BANKDRAFT: This is my authorization for Morgan-White Administrators, Inc., on behalf of VSP to draft payments from my checking account for payment of my insurance premiums. Below is the Routing Number and Checking Account number for the account on which drafts are to be drawn. Name of Bank: _____ Name as it appears on Check: _____ Routing Number (Bottom Left Corner of Check) _____ Account Number (2 nd set of numbers on bottom) _____ Credit Card: <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard Credit Card Number: _____ Exp. Date: _____ / _____ Security Code: _____ (3 digit code on back of Card)	
Last Name	First Name	MI			
Street					
City	State	Zip			
Email Address					
Social Security Number	Home Phone	Birthday	Sex		
LIST ALL DEPENDENTS TO BE COVERED BELOW					
	Last Name	First Name	MI	Birthday	Sex
Spouse:					
Dependent:					
Dependent:					
Dependent:					
Dependent:					
Dependent:					

I understand and agree that (1) the insurance shall not take effect unless the enrollment has been accepted and approved by VSP and (2) the agent does not have the authority to make or alter any contract or waive any of VSP's other rights or requirements.

Association Member's Signature _____ Date _____

For Agent Use Only

There will be a one time non-refundable \$35.00 setup fee.

Agent Name _____ Agent Number _____



Employee Benefit Brokers