



**Opticare of Utah**  
 1901 West Parkway Blvd., Salt Lake, City, UT 84119  
 800-363-0950 (www.opticareofutah.com)

**APPLICATION FOR INDIVIDUAL VISION CARE INSURANCE POLICY**

**Please print all answers.**

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

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

<b>3. Benefit Selection</b>	
<b>Vision Plan Selected</b>	

<b>4. Premium Payment</b>		
<b>Premium Payment Mode</b> <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually		<b>Amount of Premium Payment Enclosed</b> \$
<b>Payment Choice (Select one)</b> <input type="checkbox"/> Checking Account (enclose voided check) <input type="checkbox"/> Savings Account <input type="checkbox"/> Credit Card	<b>Account Number</b>	<b>Expiration Date of Credit Card</b>
<b>Financial Institution Name:</b>		

<b>5. Representations – Owner Agreement</b>
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I agree that: (1) the statement and answers given in this application are true, 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 given 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 deliver; and (6) I have received the outline of coverage.

I herby 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 withdraw by notifying the financial institution at least three business days before the withdraw is made. In the event of a withdraw 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 West Parkway Blvd, Salt Lake City Utah 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.

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Signature of Owner (Primary Insured)

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Date signed

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State in which Policy will be Delivered

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State in which Owner Signed Application

**USEA**

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Printed Name of Association Group

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Signature of Authorized Association Representative