

# ENROLLMENT FORM

Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  Male  Female

E-Mail Address: \_\_\_\_\_

As a member of **Community Eye Care direct**, you are eligible for a standard eye examination once every twelve (12) months and an eyewear allowance of \$150 once every twelve (12) months. You are responsible for paying a \$20 exam co-payment, plus any dollar amount exceeding the \$150 allowance, at the time professional services are rendered.

By joining this plan, you are authorizing Community Eye Care to bill your debit card or credit card for the annual amount of \$140. Your plan will automatically renew at the end of the membership year, and your debit or credit card will be billed accordingly, unless written notification of termination is given at least sixty (60) days prior to the renewal date.

I wish to enroll in the **Community Eye Care direct** vision plan for a minimum of twelve (12) months. I accept the terms as stated above.

Select one of the following:

VISA Card # \_\_\_\_\_

Exp Date \_\_\_\_\_

MasterCard # \_\_\_\_\_

Exp Date \_\_\_\_\_

**Please mail or fax this form to:**

**Community Eye Care direct**  
2359 Perimeter Pointe Parkway, Suite 150  
Charlotte, NC 28208

Fax: 704-426-6044

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

Upon receiving the completed form, we will mail you a membership card.  
If you have any questions, please call us at 1-888-254-4290.