MEMBER BENEFITS nysut Working to Benefit You

Voluntary Vision Care Enrollment Form

(Please print in ink)

Name (Last, First, Middle Initial) NYSUT ID Number

Home Address City State Zip

Date of Birth ( ) Home Phone ( ) Work Phone ☐ Male ☐ Female

If you are electing family coverage, list below the names of spouse and children under 26 years of age. Adult children are covered to age 26. Unmarried children 26 years of age or older, who are incapable of self-support because of mental or physical disability, are covered provided that the disability began before the age of 26.

First Name, MI Last Name (if different)	Relationship	Gender	Date of Birth
	☐ Spouse ☐ Daughter ☐ Son	☐ M ☐ F	
	☐ Spouse ☐ Daughter ☐ Son	☐ M ☐ F	
	☐ Spouse ☐ Daughter ☐ Son	☐ M ☐ F	
	☐ Spouse ☐ Daughter ☐ Son	☐ M ☐ F	
	☐ Spouse ☐ Daughter ☐ Son	☐ M ☐ F	
	☐ Spouse ☐ Daughter ☐ Son	☐ M ☐ F	
	☐ Spouse ☐ Daughter ☐ Son	☐ M ☐ F	
	☐ Spouse ☐ Daughter ☐ Son	☐ M ☐ F	

Please Indicate: Coverage Type ☐ Individual ($185/year) ☐ Family ($380/year)

(Plan year runs January 1 - December 31)

Plan Year ☐ 01/01/22 - 12/31/22

☐ Enclosed is payment for the fees indicated above; please make checks payable to: **NYSUT Member Benefits Trust**

☐ Please charge the fees indicated above to my ☐ VISA ☐ MasterCard

Account Number Expiration Date 3-Digit Security Code *(on back of card)*

Signature. *I certify that this information is true and correct.* Date

Note: Members who defraud or attempt to defraud the NYSUT Member Benefits Trust-endorsed Voluntary Vision Plan or who knowingly give false or misleading information are subject to a penalty, which may include suspension of eligibility for all Plan benefits. Members are responsible for notifying the Plan Office of any changes in marital and/or dependent status by submitting a Change of Status Card available from the NYSUT Member Benefits Trust.

New York State Insurance Law Required Disclosure: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Please send check and form to: **NYSUT Member Benefits Trust, Attn: Voluntary Vision Plan**
800 Troy-Schenectady Road, Latham, NY 12110-2455

The Davis Vision Voluntary Vision Plan is a NYSUT Member Benefits Trust (Member Benefits)-endorsed program. Member Benefits has an endorsement arrangement of 7.9% of premium. All such payments to Member Benefits are used solely to defray the costs of administering its various programs and, where appropriate, to enhance them. Member Benefits acts as your advocate; please contact Member Benefits at 800-626-8101 if you experience a problem with any endorsed program.