Dear Vision Plan Member,

We are pleased to extend the opportunity for you to retain your vision benefits through CEC with no increase in your current rates.

If you would like to continue your vision coverage with CEC, simply complete the attached enrollment packet and send the completed forms back to us.

The forms can be emailed to Ruth Fisher at rfisher@cecvision.com or mailed to:

CEC/Portability Benefit
2359 Perimeter Pointe Parkway
Charlotte, NC 28208

After we receive your completed forms, your plan will be activated on the first day of the following month. Since payroll deductions will stop, your payments will be drafted annually from either a credit card or bank account. New membership cards will be mailed to you prior to your effective date, enabling you to continue enjoying the exceptional vision benefits that are the hallmark of CEC.

If you have any questions, please don't hesitate to contact us.

Sincerely,

Jade Rollins

Jade Rollins
Director of Customer Service

Application for CEC Portability Vision Benefits

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Date of Birth: _____

Email Address: _____

Grant Parish School Board

Each member is eligible for the following benefits once every 12 months:

- **A routine eye examination** ($10 co-payment)
- **A $130 allowance for eyewear** ($25 co-payment)
- **A contact lens fitting, re-fit, or evaluation** ($30 co-payment)

Select One of the Following:	Select One of the Following:
☐ **Credit/Debit Card** **We accept all major credit cards** Card # _____ 3-Digit Security # _____ Exp. Date _____ ☐ **Checking/Savings Account** **Send a voided check for bank drafts**	

☐ Member Only	$71.64	Annually
☐ Member + One	$138.24	Annually
☐ Member + Family	$232.80	Annually

I wish to continue participating in the Community Eye Care vision plan for a minimum of twelve (12) months.
I authorize Community Eye Care to deduct my annual payment from the account listed above:

Authorized Signature: _____ Date: _____

*Please list <u>legal</u> DEPENDENT names for **Member + One, Member + Children** or **Member + Family***

Dependents	Relationship	Date of Birth	Gender
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SIGNATURE ALSO REQUIRED ON THE FOLLOWING PAGE →

Terms and Conditions

■ The Community Eye Care vision plan applies solely to routine eye examinations and the purchase of eyewear. The following are not covered under the plan: *a)* medical eye care, *b)* surgical eye care, *c)* low vision services, *d)* emergency eye care.

■ Benefits may not be carried forward to a subsequent benefit period.

■ Coordination of benefits is not permitted.

■ Family coverage includes the primary member, spouse, and any children or persons who are listed as dependents for income tax purposes.

■ Co-payments are to be paid by the member to the provider at the time professional services are rendered.

■ The member is responsible for payment to the provider of any dollar amount exceeding the eyewear allowance.

■ Vision coverage will remain in effect for a minimum of twelve (12) months, commencing on the effective date, and will automatically renew on the anniversary date for a similar term, unless terminated in writing by the member. Vision coverage cannot be terminated at any time during a twelve (12) months benefit cycle. However, if a member wishes to terminate the vision plan at the end of a twelve (12) months benefit cycle, he or she may do so by providing thirty (30) day prior written notice to Community Eye Care. Please note: Once coverage is terminated, the member will no longer be eligible to enroll in the portability benefit.

■ Members are obligated to pay for a full twelve (12) months of coverage at the time of enrollment. Payment can be made by credit card or by bank account deduction. The dollar amount of the annual payment corresponds to the coverage tier selected by the member.

■ No refunds will be issued.

■ Eligibility for vision benefits commences on the effective date.

I have read, fully understand, and agree to adhere to these terms and conditions as they apply to my Community Eye Care vision benefit.

_____

Member Signature *Date*