Agent #: _____

DAVIS VISION℠
EYECARE REFRAMED

DAVIS VISION ENROLLMENT APPLICATION

Complete this section to apply for Member coverage

Name: _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Email Address: _____

Phone Number: (_____)_____ **Sex**: ☐ Male ☐ Female

Date of Birth: _____ **Social Security #**: _____

Complete this section to add Spouse coverage

Spouse Name: _____

Sex: ☐ Male ☐ Female

Date of Birth: _____ **Social Security #**: _____

Sign and Date

Must be an active CSEA Member to enroll and retain active coverage under the Vision Plan. Members may not re-enroll in coverage if coverage under the vision plan was previously cancelled by the member unless the member is actively at work and applies for coverage within 31 days of a Life Event as defined in the Group Vision Policy Certificate of Insurance. Vision coverage will become effective on the 1st day of the calendar month following receipt of the completed enrollment form and payment, provided they are received prior to the 14th of the month.

Agreement: **I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge and that I have read the important information above.**
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 a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Signature: _____ **Date**: _____

→ → MUST TURN OVER TO SELECT PAYMENT METHOD → →

Select your Payment Method from the following 3 options:

☐ Option 1: Automatic Pension Deduction

Note: You must currently be receiving a New York State pension to select this payment method.

If you choose to have your monthly premium deducted from your New York State Pension check, please:

1. Include a check for the first 2 months premium - made payable to Pearl Carroll & Associates (your Pension Deductions will begin after the first 2 months)
   - *2 Months Member:* $22.78
   - *2 Months Member & Spouse:* $39.02
2. Sign the Pension Deduction Authorization below

Pension Deduction Authorization

Pursuant to Section 110-c and 410c of the Retirement and Social Security Law, I hereby authorize deductions to be made from my monthly allowance from the New York State and Local Employees Retirement Systems in the amount necessary to cover membership dues and insurance on my behalf to CSEA, Local 1000, AFSCME, AFL-CIO. Authorization is also given to make any changes the Union certifies to the Retirement System as necessary in the amount of such dues and insurances. I, the undersigned, do hereby authorize you to deduct from my monthly allowance the amount of $2.00 for payment of dues, or any amount as may be certified to you by the Union as my dues and or insurance. I understand that CSEA, Local 1000, AFSCME, AFL-CIO is my agent and all request to begin, modify, or revoke deductions must be submitted through the Union. This authorization shall remain in effect until revoked by me by written notice through the Union or until otherwise revoked pursuant to law.

Signature: _____ **Date**: _____

☐ Option 2: Automatic Checking Account Withdrawal

If you choose to have your monthly premium deducted from your checking account, please:

1. Include a check for the first 2 months premium - made payable to Pearl Carroll & Associates (your Automatic Checking Account Withdrawals will begin after the first 2 months)
   - *2 Months Member:* $22.78
   - *2 Months Member & Spouse:* $39.02
2. Sign the Checking Account Deduction Authorization below

Checking Account Deduction Authorization

I (we) hereby request and authorize you to effect a transfer each month on the account (name and number shown on check) for the payment of insurance premiums due during such month for the coverage that I have applied for. This authorization is to remain in effect until it is revoked by either of us in writing. Until you receive such written notice of revocation, I (we) agree that you shall be fully protected in processing such transfers. I (we) agree that if any such transfer is dishonored, the payment for insurance will be considered to be in default pursuant to the terms of the policy. This authorization shall be effective as of the date stated below. It is agreed that Pearl Carroll & Associates LLC will automatically withdraw from my account the amount necessary to pay the monthly premium for the coverage(s) that I have applied for.

Signature: _____ **Date:** _____

☐ Option 3: Direct Bill Sent to Your Home

1. **Select your billing cycle (check one):**

☐ *Quarterly* ☐ *Semi-Annual* ☐ *Annual*

2. **Include a check for your initial premium payment** - made payable to Pearl Carroll & Associates. Your initial premium payment will depend on the billing cycle you choose.

   Below is an illustration of the required initial premium payment based on your billing cycle.

Quarterly	*Semi-Annual*	*Annual*
Submit 3 months premium	Submit 6 months premium	Submit 12 months premium

*The Direct Bill option requires an additional fee of $6.00 per bill