

# PLAN B-1

## Vision Plan for Individual, Couples and Families

### What are the Benefits?

After a \$10.00 Annual Deductible per Person	COSTS	FREQUENCY
<b>COMPLETE EYE EXAM AND PRESCRIPTION</b> (With a follow-up visit at Enrollee request) <b>*LENSES</b> (Medically necessary-Ophthalmic)	<b>NO CHARGE</b>	<b>EACH 12 MONTHS</b>
<b>SINGLE VISION LENS</b>	<b>NO CHARGE</b>	<b>EACH 12 MONTHS</b> (If needed)
<b>BIFOCAL LENS</b>	<b>NO CHARGE</b>	<b>EACH 12 MONTHS</b> (If needed)
<b>TRIFOCAL LENS</b>	<b>NO CHARGE</b>	<b>EACH 12 MONTHS</b> (If needed)
<b>FRAME</b> (Standard – VPA Metal or ZYL) <b>*See Schedule of Extras for basic benefit</b>	<b>NO CHARGE</b> <b>UP TO \$90 RETAIL</b>	<b>EACH 24 MONTHS</b> (If needed)

(\*includes tint #1 any color plastic lenses only)

COSMETIC CONTACT LENSES are available in addition to your Basic Benefit (see Schedule of Extras provided at your Doctor’s office); or, if desired in lieu of all other services, \$100 applies to the Doctor’s usual and customary package fee. Package fee = examination, fitting, follow-up and contact lenses. Cosmetic Contact Lenses are available each 12 months if a change is indicated. \$100 may also apply toward an annual contact lens supply of disposable contact lenses. Fitting may have an added cost.

MEDICALLY NECESSARY CONTACT LENSES are available each 24 months if a change is indicated. This benefit includes: A special contact lens examination, follow-up visits and **medically necessary contact lenses. This is a \$250 benefit.**

### How do I join?

1. Complete the attached enrollment form.
2. You will find the Optometric Office Code Numbers next to the provider’s name when using our provider locator. **Choose a conveniently located Doctor and transfer the Code Number onto the Enrollment Form.**
3. Sign and date the Enrollment Form. Please be sure we have your correct address.
4. Submit the Enrollment Form to:

**NoCobra.com, Inc.**  
27 Lazurite, Suite 100  
Rancho Santa Margarita, CA 92688  
Phone: (949) 713-7222  
Fax: (949) 713-7278

5. Co-payments, if any or any additional fees you incur not covered by the plan will be paid directly to the Doctor, including a one-time deductible. Please refer to your “Evidence of Coverage” for the co-payment and deductible you may have to pay.

### HOW DO YOU RECEIVE CARE?

Upon completion of processing you will receive a personal identification card. Simply call the office you selected for an appointment as you usually would. Present your Plan I.D. Card at the time of your appointment. There are no claim forms to fill out.

### WHEN WILL BENEFITS BEGIN?

Those who join prior to the 20<sup>th</sup> of the month will begin benefits the first day of the following month. Children are eligible up to age 19 and extended to age 23 if a full time student and claimed by you for Federal Income Tax purposes.

- 1) PLEASE PRINT THIS FORM
- 2) COMPLETE ALL INFORMATION
- 3) PLEASE SIGN
- 4) MAIL TO:

**Individual Plan B-1**

**NoCobra.com, Inc.**  
**27 Lazurite, Suite #100**  
**Rancho Santa Margarita, CA 92688**

OR  
**FAX TO:**

**(949) 713-7278**

Agent of Record:  
 Name: \_\_\_\_\_  
 VPA Code # \_\_\_\_\_


Do not write in shaded areas

JOIN TODAY

NAME \_\_\_\_\_  
LAST                      FIRST                      INITIAL

ADDRESS \_\_\_\_\_ APT.# \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE(\_\_\_\_) \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_  
NAME

COVERED DEPENDENTS – List Eligible Dependents (Same Residence)

\_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
SPOUSE

\_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
CHILDREN

\_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
CHILDREN

\_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
CHILDREN

OPTOMETRIST

CODE NUMBER \_\_\_\_\_

**IMPORTANT**

Visit [www.visionplanofamerica.com/providers](http://www.visionplanofamerica.com/providers) for a list of providers.  
**PLAN B-1 INDIVIDUAL**

**I WISH TO PAY MY ANNUAL PREMIUM IN FULL**  
 \*\*Annual by credit card – see CREDIT CARD INFORMATION below  
 \*Annual by check – Payable to: Vision Plan of America  
 Individual \$114.00  Member + 1 Dependent \$195.00  Family \$245.00  
 This includes a 1 time non-refundable \$10.00 enrollment fee

**I WISH TO PAY MY PREMIUM MONTHLY by Credit Card or EFT**  
 Individual \$9.50  Member + 1 Dependent \$17.60  Family \$22.40  
 Monthly payment by **credit card**, please fill in credit card information below\*\*  
 Monthly payment by check, 1<sup>st</sup> month's payment enclosed (**please add a \$10.00 one time non-refundable enrollment fee**). \* **BE SURE TO INCLUDE A VOID CK** \*  
 I hereby authorize **VISION PLAN OF AMERICA** to charge my credit card/checking account each months applicable Vision Plan premium to be credited to my account with **Vision Plan of America**. This authority is to remain in full force and effect until I notify **Vision Plan of America** in writing of my termination, thirty days thereafter vision benefits will end. **A one time, non-refundable \$10.00 enrollment fee will be added to the credit card draft.**  
 I wish to enroll in the Vision Plan of America Program. I understand that all necessary services will be provided as described in the Evidence of Coverage and **this contract is for a minimum of 24 months.**

Visa  MasterCard  Discover  Diners Exp. Date \_\_\_\_\_

Credit Card # \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_  
**SIGNATURE REQUIRED FOR ENROLLMENT**

**\*\*\*PLEASE BE SURE TO SIGN THIS FORM\*\*\***  
**ENROLLMENT INFORMATION**  
 All enrollment information received prior to the 20<sup>th</sup> of the month will be effective on the first of the following month



**Referral Program- We need your help...please don't keep us a secret!**  
Return this form by mail, fax, or just *visit our Referral Program page on the website!*

**www.NoCobra.com**

**Client Referral Form**

**Refer your friends, family, and business associates that you feel may benefit from receiving information on dental, life or health insurance. This form is kept confidential and is not sold to a third party.**

**The following contacts have been referred by:**

**Name:** \_\_\_\_\_ **e-mail:** \_\_\_\_\_

Referral #1

Name: \_\_\_\_\_ e-mail: \_\_\_\_\_

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

City / Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Cellular Phone: \_\_\_\_\_ Work: \_\_\_\_\_

This person is expecting you to contact them via phone or e-mail.  You may use my name.

Referral #2

Name: \_\_\_\_\_ e-mail: \_\_\_\_\_

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

City / Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Cellular Phone: \_\_\_\_\_ Work: \_\_\_\_\_

This person is expecting you to contact them via phone or e-mail.  You may use my name.

Referral #3

Name: \_\_\_\_\_ e-mail: \_\_\_\_\_

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

City / Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Cellular Phone: \_\_\_\_\_ Work: \_\_\_\_\_

This person is expecting you to contact them via phone or e-mail.  You may use my name.

**Return this completed form to NoCobra.com via:**

<b>Fax:</b> (949) 713-7278 [24 hrs/day]	<b>Mail:</b> NoCobra.com, Inc.
<b>E-mail:</b> referrals@nocobra.com	27 Lazurite, Suite #100
<b>Call:</b> (949) 713-7222 or Toll Free: (866) 662-6272	Rancho Santa Margarita, CA 92688

**MONTHLY DRAWING**

Our Monthly Drawing is for *clients only!* Give a referral and get a chance to win a \$40 gift certificate for dinner, tickets to an Angels baseball game or tickets to a Mighty Ducks hockey game for providing a referral.

**Rules:** 1) You must be a current client to have (1) raffle ticket for each name submitted into the monthly drawing. 2) The drawing will be held on the last Friday of every month. 3) Names must be submitted by Thurs (the day before) at midnight. 4) To qualify, the names submitted must have a corresponding e-mail and/or telephone number. 5) The winner must have a valid e-mail address and be an existing client to qualify.

**Prizes:** The winner will be notified via e-mail within one week of the drawing and will select from one of the following:

**GIFT CERTIFICATE** - To a restaurant of your choice **HOCKEY TICKETS** - Mighty Ducks of Anaheim game **BASEBALL TICKETS** - Anaheim Angels game \$40 Personal Check - Only in certain situations