PENNSYLVANIA ASSOCIATION OF RETIRED STATE EMPLOYEES

Vision Application

DAVIS VISION
EYECARE REFRAMED℠

Please see other side on how to apply...

PLEASE PRINT CLEARLY.

PARSE MEMBER - APPLICANT

Social Security Number	Last Name	First	M.I.
– –			

Street Address	Telephone
	( )

City	State	Zip	Sex	Birth Date (Mo/Day/Yr)
			☐M ☐F	/ /

Email ☐ **YES** *I would like to receive Paperless correspondence and/or Renewal Invoices via email.*

COVERAGE DESIRED & ANNUAL PREMIUMS *(Please ✔ one)*

Premiums include a Third Party Administration fee.

STANDARD PLAN		
☐ Individual (Applicant Only) **$74**	☐ Two-Party (Applicant Plus One) **$131** *enter information below*	☐ Family (Applicant Plus Two or More) **$190** *enter information below*
ENHANCED PLAN		
☐ Individual (Applicant Only) **$90**	☐ Two-Party (Applicant Plus One) **$162** *enter information below*	☐ Family (Applicant Plus Two or More) **$250** *enter information below*

FAMILY MEMBERS - DEPENDENTS

	Social Security No.	Last Name	First	M.I.	Sex M/F	Birth Date Mo/Day/Yr	Disabled Yes/No
Spouse							
→ **For disabled dependent children age 26 or older call 1-800-382-1352 for a Dependent Certification form.** ←							
Child							
Child							
Child							

PAYMENT METHOD

☐ ***Enclosed Check/Money Order*** *(please make check payable to "PISI")*

Credit Card: *Card No.*_____ *Exp. Date* _____ *CVV Code** _____

*Three digit code on back of card

Please check one…

☐ ***MasterCard***
☐ ***Visa***
☐ ***Discover***

Cardholder's Name, as it appears on Credit Card

Cardholder's Address (if different from applicant)

X _____ X _____

Signature (for Credit Card authorization only) *Date*

Important—Please read and sign below: *Any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance or statement of claim containing any materially false information or conceals for the purposes of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.*

I hereby apply for the coverage indicated, and understand that the premium payment is for 12 months of coverage and is not refundable for any reason. If I do not renew my contract at the end of the 12 months, I cannot re-enroll for 36 months. I further understand that my enrollment is subject to receipt of payment in the correct amount. If a check is returned for any reason, a $20.00 fee will be charged.

X _____ X _____

Applicant's Signature ***Date***

HOW TO APPLY:

1. To apply for Vision coverage, complete this Application. To apply for both Dental **and** Vision Plans, fully complete, sign and date **both** Dental and Vision Applications.

2. Check the Coverage you desire: **Individual; Two-Party** (member and spouse or member and child); or **Family** (member plus two or more dependents). Unmarried dependent children can be enrolled up to age 26, disabled dependents to any age. ***If enrolling a disabled dependent age 26 or older please call 1-800-382-1352 for a Dependent Certification form which must be completed and returned with your application.***

ANNUAL VISION PREMIUMS		
	STANDARD PLAN	**ENHANCED PLAN**
Individual	**$74**	**$90**
Two-Party	**$131**	**$162**
Family	**$190**	**$250**

3. Full annual premiums must be submitted for the type of coverage you choose. Payment options are: check; MasterCard, Visa or Discover credit cards; money order; or Monthly Withdrawal from your checking account*. Checks are to be made payable to "PISI". You may send one check/money order to cover the combined premiums if you choose both Dental and Vision. A $20.00 fee will be charged for any checks returned due to insufficient funds.
   If you choose the "MONTHLY WITHDRAWAL" option for the Vision coverage you are agreeing to pay the full annual premium. Please complete the enclosed Authorization for Monthly Withdrawal Form.

4. Mail the fully completed Application(s) and your payment using the enclosed postage-paid envelope to: Professional Insurance Services, Inc., 2 Kacey Court, Suite 102, Mechanicsburg, PA 17055. **If your Application(s) and payment are received at PISI by the 20th of the current month, the coverage will become effective the first of the following month**. You will receive an identification card from Davis Vision.

IMPORTANT NOTICE:

The Pennsylvania Association of Retired State Employees has as its primary function the advancement and protection of the State Retirees' pension and health benefits.
However, additional PARSE benefits offered are dental, vision, and other insurance policies. These benefits are available to retirees and spouses who are fully paid members of PARSE.
PARSE routinely checks membership records to assure compliance. Any payment of insurance premiums is not related to the annual PARSE membership fee.
Therefore, those who initially enroll or renew their dental/vision policy should be certain that their PARSE annual dues are paid. (PARSE dues are based on a calendar year).
Questions can be directed to the Harrisburg office (731-9522) or, outside of the area, the PARSE toll-free number (1-888-809-7429).