APPLICATION FOR INDIVIDUAL VISION CARE INSURANCE POLICY
Opticare of Utah
1901 West Parkway Blvd., Salt Lake, City, UT 84119
800-363-0950 (www.opticareofutah.com)

Please print all answers.

1. Owner (Applicant) – Owner is the Primary Insured			
(a)Owner Name (First/Middle/Last):			(b)Sex: ☐ Male ☐ Female
(c)Date of Birth (Mo./Day/Yr):	(d)Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed		(e)Social Security Number
(f)Home Address (Street, City, State, Zip Code):		(g) E-mail Address: (optional)	(h) Home Phone Number

2. Dependents (Indicate the names of all dependents to be insured under the policy.)					
Name	**SS#**	**Date of Birth**	**Name**	**SS#**	**Date of Birth**
Spouse:			Child:		
Child:			Child:		
Child:			Child:		

3. Benefit Selection	
Vision Plan Selected	

4. Premium Payment		
Premium Payment Mode ☐ Monthly ☐ Annually		**Amount of Premium Payment Enclosed** **$**
Payment Choice (Select one) ☐ Checking Account (enclose voided check) ☐ Savings Account ☐ Credit Card (only available if paying annually)	**Account Number**	**Expiration Date of Credit Card**
Financial Institution Name:		

5. Representations – Owner Agreement

I agree that: (1) the statement and answers given in this application are true, and correctly recorded to the best of my knowledge and belief; (2) this application will be part of the contract for which I apply; (3) the policy is a one year contract that is guaranteed renewable in accordance with the terms of the policy; (4) I understand that this policy must remain in force for a 12-month period and that premiums are due for the entire 12 month period; (5) I understand that this policy will be renewed on each policy anniversary date for a new 12-month period unless given written notification to Opticare of Utah to terminate the policy 60 days prior to the policy renewal date. I will notify the insurer if any statements or answers given in this application change prior to policy deliver; and (6) I have received the outline of coverage.

I herby authorize Opticare of Utah to withdraw premium payments from the financial institution and account named above under section 4 of this application. I understand that this authorization will remain in effect until the financial institution has received and has had reasonable time to act on a written request from me to terminate this agreement. I understand that I can stop a withdraw by notifying the financial institution at least three business days before the withdraw is made. In the event of a withdraw error, I must promptly notify the financial institution to preserve any rights I may have. I understand that I may direct my billing inquiries to Opticare of Utah, 1901 West Parkway Blvd, Salt Lake City Utah 84119.

No licensed insurance agent is authorized to: (a) make or modify contracts; (b) waive any insurer rights or requirements; and (c) waive any information the insurer requests.

Any person who knowingly presents a false of fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

The policy provides vision benefits only. Review your policy carefully.

Signature of Owner (Primary Insured) _____ Date signed _____

State in which Policy will be Delivered _____ State in which Owner Signed Application _____

Printed Name of Licensed Insurance Agent _____ Signature of Licensed Insurance Agent _____ Agent License Number _____

OOU.IND.APP.

Fax to: **801-305-4947** OR Mail to: **ARK Insurance Solutions**
655 East 4500 South, Ste 210
Salt Lake City, UT 84107