Republic Underwriters, Inc.
Vision Care Insurance

	Plan 1	Plan 2	Plan 3
Exam	Once every 12 months 100% less a $10.00 co-pay Up to $30.00	Once every 12 months 100% less a $10.00 co-pay Up to $30.00	Once every 12 months 100% less a $10.00 co-pay Up to $30.00
Spectacle Lenses	Once every 12 months 100% less a $10.00 co-pay $25.00 Single Vision $35.00 Bifocal $45.00 Trifocal $45.00 Lenticular	Once every 12 months 100% less a $10.00 co-pay $25.00 Single Vision $35.00 Bifocal $45.00 Trifocal $45.00 Lenticular	Once every 12 months 100% less a $25.00 co-pay $25.00 Single Vision $35.00 Bifocal $45.00 Trifocal $45.00 Lenticular
Frames	Once every 24 months 100% up-to $100 $50.00	Once every 24 months 100% up-to $120 $70.00	Once every 24 months 100% up-to $120 $70.00
Contact Lenses	Once every 12 months 100% up-to $100 100% Medically necessary to $80.00 Elective & $200.00 Medically Necessary up to $200.00	Once every 12 months 100% up-to $115 100% Medically necessary to $90.00 Elective & $220.00 Medically Necessary up to $220.00	Once every 12 months 100% up-to $115 100% Medically necessary to $90.00 Elective & $220.00 Medically Necessary up to $220.00
Member	**$6.41 per month**	**$7.02 per month**	**$6.02 per month**
Member Plus One	**$11.54 per month**	**$12.63 per month**	**$10.83 per month**
Member Plus two or more	**$16.66 per month**	**$18.25 per month**	**$15.64 per month**

Medically Necessary Contact Lenses– In instances where contact lenses are determined to be medically necessary, coverage will be at 100% of the providers reasonable and customary fee up to the dollar amount indicated in the above table. Prior authorization required

= Participating Providers = Out-of-Network Providers

Product Highlights

- Vision Care is always rated at or near the top of the list of benefits most desired by members.
- Vision Care programs may help eliminate loss in productivity and absenteeism due to headaches, eyestrain and fatigue
- Program offers a large national network of tens of thousands of participating Ophthalmologists, Optometrists and Opticians
- Proper vision care can help in the detection of certain medical conditions such as diabetes and multiple sclerosis
- Programs are simple to use and do not require use of claim forms

CHARTIS
Your world, insured

Please contact:

Scott W. Dickinson, President
P.O. Box 1197 Troy, MI 48099-1197
Toll-Free Phone: 800-248-0438 ext.1015
Fax 248-641-8857
www.republicund.com

INDIVIDUAL APPLICATION
FOR VISION COVERAGE
(Please Print or Type)

Employer (Group) Name **Republic Underwriters Inc.**		Group# / Division / Class **50598**	
Applicant's Last Name	First	Middle Initial ❑ Male	❑ Female
Social Security Number – Last 4 digits only		Date of Birth: (Month / Day /Year)	
Street Address	City	State	Zip
Telephone #: ( )		Email:	
VISION COVERAGE TYPE REQUESTED: ❑ Member ❑ Member + One ❑ Member + Two or More		❑ Plan 1 ❑ Plan 3 ❑ Plan 2	

EFFECTIVE DATE: First of Following Month After Approval
NOTE: IF PAYING BY CHECK, PLEASE SEND ONE YEARS PREMIUM

COMPLETE: THE FOLLOWING FOR ALL FAMILY MEMBERS FOR WHOM YOU ARE REQUESTING COVERAGE

LAST NAME	FIRST NAME	INITIAL	STUDENT (Yes / No)	M / F	DATE OF BIRTH Month / Day / Year
Spouse					

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAIN A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

I HEREBY APPLY FOR ENROLLMENT FOR VISION COVERAGE.

SIGNATURE **DATE**

Enclose your annual check or fill in your Visa / MasterCard information below.

Scott W. Dickinson, President
P.O. Box 1197 Troy, MI 48099-1197
Toll-Free Phone: 800-248-0438 ext.1015
Fax 248-641-8857
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Name: _____

Card Number: _____

Expiration Date: _____

CVV2# (last 3 digits on back of card _____

Signature: _____

❑ Please re-bill my card annually.