VCD PLUS

YOUR PLAN. YOUR CHOICE.

At last, you finally have the freedom to use your materials allowance the way you want without all the surprise out of pocket expenses. With VCD PLUS providers in your area, you'll have access to high definition (single vision, bifocal, trifocal or premium progressive) lenses, premium anti-reflection coating, scratch resistant coating and UV protection all for one low price!

FRAME	$130 Allowance	✔
LENSES	Single Vision	✔
	Bifocal	✔
	Trifocal	✔
Super charge your benefits at VCD PLUS providers*	**HD Progressive (No-line)**	✔
	Anti-Reflective Coating	✔
	Scratch Resistance	✔
	UV Protection	✔
	Oil & Water Repellent	✔

- Progressive lens coverage on the Standard VCD option is equal to doctor's retail cost of standard trifocal lens. Difference between retail cost of progressive and trifocal lens is patient responsibility.
- Lens enhancements not listed as covered options above (polycarbonate, high-index, photochromic, etc.) can be added at doctor's usual and customary rate.
- Contact lens benefit of $130 may be used in lieu of the spectacle lens benefit options listed above.
- VCD PLUS benefits listed above are exclusively available from providers listed on our website (www.visioncaredirect.com) with the PLUS Plan logo: VCD PLUS

SIMPLE. FLEXIBLE. AFFORDABLE.

www.JDThompsonInsurance.com

J. D. Thompson Insurance
3500 N Rock Rd #300-A
Wichita, Ks. 67226-1330
Voice: 316-722-9070
Fax: 833-561-2600

SAVE UP TO 60% ON YOUR EYECARE TODAY!

The #1 Choice for Vision Coverage

Vision Care Direct

Vision Care Direct is a membership plan, not insurance.

Individual and Family Plans available. See inside for details.

USE YOUR INDIVIDUAL PLAN

from Vision Care Direct to save money on:

Comprehensive Eye Exams

Our doctors perform comprehensive eye exams including refraction and dilation of your pupils when indicated, which can help detect up to 16 different eye and general health conditions.

- Fee at time of service: $15
- Available on Exam Only and Exam + Materials Plans
- Benefit renews every 12 months from enrollment date

Glasses or Contacts

Get the latest fashion eye wear and full range of high-technology opthalmic lenses (including free-form progressives, single-vision and bifocals) for the entire family!

- Fee at time of service: Varies. See information regarding the three ways to save on glasses in your doctor's office
- Contact lens benefit of $130 can be chosen in lieu of glasses. No fee at time of service on contact lenses
- Available on Materials Only and Exam + Materials Plans
- Benefit renews every 12 months from enrollment date

KANSAS ENROLLMENT FORM

To enroll, simply complete the enrollment form below and return to: J. D. Thompson Insurance; 3500 N Rock Rd. #300-A, Wichita, KS 67226.
If paying annually via credit/debit card, you may fax this application to (833) 561-2600.
You can also enroll online at www.JDThompsonInsurance.com.

MONTH TO BEGIN PLAN (Starts on the 1st): _____

LAST NAME	FIRST NAME	M.I.	BIRTHDATE (MM/DD/YY)	GENDER ☐ M ☐ F
ADDRESS	CITY	STATE	ZIP	
EMAIL ADDRESS (REQUIRED FOR RENEWAL NOTIFICATION)	HOME PHONE	WORK PHONE	MARITAL STATUS ☐ SINGLE ☐ MARRIED	

FAMILY MEMBERS Enroll only family members for whom membership is desired. You need not enroll all family members.

SPOUSE LAST NAME	FIRST NAME	M.I.	BIRTHDATE (MM/DD/YY)	GENDER ☐ M ☐ F
DEPENDENT LAST NAME	FIRST NAME	M.I.	BIRTHDATE (MM/DD/YY)	GENDER ☐ M ☐ F
DEPENDENT LAST NAME	FIRST NAME	M.I.	BIRTHDATE (MM/DD/YY)	GENDER ☐ M ☐ F
DEPENDENT LAST NAME	FIRST NAME	M.I.	BIRTHDATE (MM/DD/YY)	GENDER ☐ M ☐ F
DEPENDENT LAST NAME	FIRST NAME	M.I.	BIRTHDATE (MM/DD/YY)	GENDER ☐ M ☐ F

CHOOSE FROM TWO PAYMENT OPTIONS:

MONTHLY

Mark your desired plan and authorize automatic monthly credit card payments.

PLAN	SINGLE	2 MEMBERS	3 MEMBERS	4+ MEMBERS
EXAM ONLY	☐ $6.04	☐ $11.17	☐ $17.26	☐ $22.64
MATERIALS ONLY	☐ $15.47	☐ $29.04	☐ $44.62	☐ $58.71
EXAM + MATERIALS	☐ $21.49	☐ $40.22	☐ $61.89	☐ $81.34

☐ I hereby authorize Vision Care Direct to charge my account the contribution amount selected above each month, and will remain in full force and effect until I notify Vision Care Direct in writing of termination (Cancellation requests can be sent via email to cancel@visioncaredirect.com and must include Member Name, Member ID Number and Date of Birth). I agree to maintain membership for a period of no less than one year (12 months). Less than one year membership will result in the remaining membership contributions to become immediately due and payable. I acknowledge that my membership will automatically renew each year if no action is taken before 30 days from the plan end date.

ANNUAL

Mark your desired plan and select method for one-time payment.

PLAN	SINGLE	2 MEMBERS	3 MEMBERS	4+ MEMBERS
EXAM ONLY	☐ $72.40	☐ $134.01	☐ $207.16	☐ $271.75
MATERIALS ONLY	☐ $185.55	☐ $348.38	☐ $535.43	☐ $704.47
EXAM + MATERIALS	☐ $257.97	☐ $482.52	☐ $742.72	☐ $976.09

☐ I hereby authorize Vision Care Direct to make a one-time charge to my account for the annual contribution amount selected above. I agree to maintain membership for a period of no less than one year (12 months). Cancellation requests can be sent via email to cancel@visioncaredirect.com and must include Member Name, Member ID Number and Date of Birth. Less than one year membership will result in any remaining membership contributions to become immediately due and payable. I acknowledge that my membership will automatically term at the end of the plan year unless I notify Vision Care Direct of my intent to renew my membership or make changes to my plan benefit options.

PAYMENT INFORMATION

CARDHOLDERS' NAME (AS IT APPEARS ON THE CARD)			PAYMENT METHOD ☐ VISA ☐ ☐ DISCOVER
CREDIT CARD NUMBER	EXP DATE	SECURITY CODE	ZIP CODE

Subscriber's Signature: _____ **Date:** _____/_____/_____

Broker/Doctor Name: J.D. Thompson- 490 Promo Code: JDTHOMPSON