Independence

For office use only
Application ID: _____
Account ID: _____

Application for Adult Vision Care Individual Coverage
The Adult Vision Individual Coverage is underwritten by QCC Insurance Company*

In order to be eligible for coverage, the following must be true:

- The primary applicant must be 19 or older.
- Applicants must be residents of Bucks, Chester, Delaware, Montgomery, or Philadelphia counties in Pennsylvania.
- Dependent children must be between 19 – 26 years old.

SECTION A — Plan Selections

Type of coverage	Reason for application	Method of payment	For office use only
☐ Individual ☐ Individual and spouse or domestic partner ☐ Individual and dependent child(ren) ☐ Family	☐ New enrollment ☐ Add spouse or domestic partner ☐ Add dependent child(ren) ☐ Renewal (plan change)	☐ Check enclosed ☐ Credit Card / Debit Card / Pre-Paid Debit Card (first payment only) – call 1-888-879-4891 or visit ibx4you.com/payment	Effective Date _____

Choice of Plan	
Standalone Vision Care	
☐ Vision Care 150	☐ Vision Care 200

SECTION B — Primary Applicant Information (must be 19 or older)

Primary applicant name: Last, First, Middle initial			
Social Security Number (required)	Birth date (mm/dd/yy) ____/____/_____	Age	Gender: ☐ M ☐ F

*Available to eligible individuals only (see section G: Declarations and Conditions of Enrollment).

SECTION C — Family Information (if applying)

Spouse or Domestic Partner name: Last, First, Middle initial			
Social Security Number (required)	Birth date (mm/dd/yy) ____/____/____	Age	Gender: ☐ M ☐ F

Dependent name: Last, First, Middle initial			
Social Security Number (required)	Birth date (mm/dd/yy) ____/____/____	Age	Gender: ☐ M ☐ F

Dependent name: Last, First, Middle initial			
Social Security Number (required)	Birth date (mm/dd/yy) ____/____/____	Age	Gender: ☐ M ☐ F

Dependent name: Last, First, Middle initial			
Social Security Number (required)	Birth date (mm/dd/yy) ____/____/____	Age	Gender: ☐ M ☐ F

SECTION D — Personal Information

Residence address			Mailing address (if different from residence address)		
Street (P.O. Box not acceptable)			Street		
City	State	ZIP code	City	State	ZIP code
County			County		

SECTION E — Contact Information

Home phone number ( )	Mobile phone number ( )	Email address
Best time to call: ☐ Morning ☐ Afternoon	Best location to call: ☐ Home ☐ Mobile	

SECTION F — Household Information

A. Do all applicants reside in the same household? ☐ Yes ☐ No

If no, provide reason: ____________________ Address: ____________________

B. Do all applicants reside in one of the following counties: Bucks, Chester, Delaware, Montgomery, or Philadelphia? ☐ Yes ☐ No

If no, provide reason: ____________________ Address: ____________________

Form #16922 (Rev. 1.23)

SECTION G — Declarations and Conditions of Enrollment *Please read carefully before signing below.*

By applying to QCC Insurance Company ("the company") for coverage for myself and the dependents listed in Section C, I understand and agree to the following:

1. a) For your effective coverage date, please see the information in the Premium Rate Letter.
   b) Coverage does not begin until this application is processed by the company with an effective date of coverage assigned and payment has been received.
   c) Credit card/debit card payments and pre-paid debit card payments are acceptable for the first month's premium payment only.
   d) Receipt of the initial payment does not constitute enrollment under any program.
   e) This coverage is provided only to residents of the geographical area of Bucks, Chester, Delaware, Montgomery, and Philadelphia counties, Pennsylvania, served by the company. The company reserves the right to investigate and confirm your residence.
2. The company may void this non-group benefit policy within three (3) years of the effective date if it is found that this non-group benefit policy was obtained or maintained by intentionally supplying a material misrepresentation of fact, except in the case of fraud, for which there is no time limit for voiding the policy.
3. The terms and conditions of the coverage will be controlled by the written agreement with the company, and the company may adopt policies, procedures, rules, and interpretations to administer benefits under the policy. It is recognized that the coverage will only apply to admissions that occur and services that are provided on or after the effective date of coverage.
4. By enrolling in this benefit program, I acknowledge that in connection with the administration of, or delivery or receipt of benefits, under the non-group policy, the company will use and disclose PHI (protected health information) for purposes of Treatment, Payment, and Operations (TPO) as this term is defined by federal law.
5. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose 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.
6. I can confirm that no one applying for health insurance on this application is incarcerated (detained or jailed).

Signature(s) Required

I acknowledge that I have read, understand all statements in this application, and have supplied the requested information. The information supplied on the application and any signed addendum is accurate and complete to the best of my knowledge. No material information has been withheld or omitted on any person applying. I understand that if my signature and date do not appear and/or my answers are incomplete, the application will either be rejected or returned for completion.

SIGN HERE X _____ Applicant/Parent or Legal Guardian signature ___/___/_____ Date (mm/dd/yy)

SIGN HERE X _____ Applicant spouse or domestic partner signature (if applying for coverage) ___/___/_____ Date (mm/dd/yy)