Dear City of Tampa Retiree,

Superior Vision is pleased to be offering vision benefits to all eligible City of Tampa Retirees. Through our Direct Bill program, you will be able to obtain vision benefits for yourself and your qualified dependents.

Enclosed is a benefit outline and enrollment form with quarterly rates. Premium is collected via a quarterly billing process for each quarter you remain on the plan. An ID card will be sent to you once your enrollment and payment have been processed.

If you would like to elect coverage, please complete the enclosed enrollment form and return to the below address with your check or money order made payable to Superior Vision.

Superior Vision
Attn: City of Tampa Retiree Services
P.O. Box 509
Troy, NY 12181

If you have any questions, you may reach out to your designated **Client Manager, Mr. John Parker at (916) 204-9689.** Office hours are Monday through Friday, from 9:00 am to 5:00 pm EST time.

We hope that you will consider electing coverage. Thank you for your kind attention.

Sincerely,

John Parker
Manager, Client Services
Superior Vision

MetLife

Metropolitan Life Insurance Company, New York, NY 10166

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Network / Administered by: Superior Vision Services 881 Elkridge Landing Rd Ste 300, Linthicum Heights, MD 21090

Name of Group Customer/Employer	Group Customer #	Superior Vision: Location Code
City of Tampa Retirees	**DM13011900**	**03-Retirees**
Coverage Effective Date (MM/DD/YYYY)	Termination Effective Date (MM/DD/YYYY)	

YOUR ENROLLMENT INFORMATION (To be Completed by the Retiree)

Name (First, Middle, Last)	Social Security # – –	Alternate ID #
Address (Street, City, State, Zip Code)		Date of Birth (MM/DD/YYYY)
Phone #	Email Address	☐ New Enrollment ☐ Change in Enrollment

☐ Male ☐ Female ☐ Gender X (not exclusively male or female, e.g., non-binary, agender, intersex, or gender non-conforming)

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible.

The following disclosure is required by New Mexico law: **This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.**

Vision Insurance

First select your option

Plan Option _____

Then select your level of coverage

☐ Retiree Only	$14.76	☐ Retiree + 1 Dependent	$29.58
☐ Retiree + Family	$49.41		

GEF02-1
ADM
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana*;
GEF02-1
ADM *applies to residents of North Dakota and Utah)*

SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original to:

Superior Vision Services P.O. Box 509 Troy, NY 12181

MetLife
Metropolitan Life Insurance Company, New York, NY 10166

Dependent Information

If you are applying for coverage for your Spouse and/or Child(ren), please provide the information requested below:

Name of your Spouse (First, Middle, Last) ______	Date of Birth (MM/DD/YYYY) ______	☐ Male ☐ Female ☐ Gender X	☐ Add ☐ Terminate ☐ Change	☐ Disabled person
Name(s) of your Child(ren) (First, Middle, Last) ______	Date of Birth (MM/DD/YYYY) ______	☐ Male ☐ Female ☐ Gender X	☐ Add ☐ Terminate ☐ Change	☐ Disabled person
______	Date of Birth (MM/DD/YYYY) ______	☐ Male ☐ Female ☐ Gender X	☐ Add ☐ Terminate ☐ Change	☐ Disabled person
______	Date of Birth (MM/DD/YYYY) ______	☐ Male ☐ Female ☐ Gender X	☐ Add ☐ Terminate ☐ Change	☐ Disabled person
______	Date of Birth (MM/DD/YYYY) ______	☐ Male ☐ Female ☐ Gender X	☐ Add ☐ Terminate ☐ Change	☐ Disabled person
______	Date of Birth (MM/DD/YYYY) ______	☐ Male ☐ Female ☐ Gender X	☐ Add ☐ Terminate ☐ Change	☐ Disabled person
______	Date of Birth (MM/DD/YYYY) ______	☐ Male ☐ Female ☐ Gender X	☐ Add ☐ Terminate ☐ Change	☐ Disabled person

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

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FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York (only applies to Accident and Health Insurance): 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

Pennsylvania and all other states: 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.

GEF09-1
FW
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GEF09-1
FW *applies to residents of North Dakota and Utah)*

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I declare that I am actively at work on the date I am enrolling.
3. I understand that if I do not enroll for vision coverage during the initial enrollment period, I cannot enroll for such coverage until the next annual enrollment period.
4. Where applicable, I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.
5. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

Signature of Retiree	Print Name	Date Signed (MM/DD/YYYY)

GEF09-1
DEC
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GEF09-1
DEC *applies to residents of North Dakota and Utah)*