

National Association of Vision Care Plans

*Confidential information provided on this form will never be released to the public or internally without express written consent.
Cumulative information may be published, only for the purposes of the Association.*

Membership Information

Company Name:		
Co. Address:		
City:	State:	ZIP:
Telephone:	Fax:	
Web address:		
Description of business:		

Contact Information

CEO:		
Marketing Officer:		
Designated Association Representative:		
	Telephone:	Email:

Additional Members

<i>Names of additional staff who will volunteer in the Association:</i>		
<u>Name</u>	<u>Area of Expertise</u>	<u>Phone</u>

Contact Person for Press Issues:	
Name:	Phone:
Contact Person: Medical Officer:	
Name:	Phone:
Contact Person for Legal Issues:	
Name:	Phone:

Coverage Information

	<u>No. of Covered Lives</u>	
Total Managed Vision Care:		
Full Service Plans:		
Discount Plans:		
Health Plans/MCO's:		
Other:		

Financial Information

Total Gross Annual Revenue		
Signature of person completing this form:		
		Date:

Please return to NAVCP, 7150 Winton Drive, Suite 300, Indianapolis, Indiana 46268;
Phone: 317-328-4633; Fax: 317-328-4629; Email: singram@navcp.org