

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:

Sent completed form to NAVCP, 9100 Purdue Road, Suite 200, Indianapolis, IN 46268
 Phone: 317.328.4633 Fax: 317.280.8527 Email: singram@navcp.org