

WELCOME TO



INDEPENDENT DOCTORS OF OPTOMETRIC CARE

The pre-eminent practice development group

MEMBERSHIP ENROLLMENT KIT EXCLUSIVELY FOR MEMBERS OF
THE ARIZONA EYECARE ALLIANCE



Information for your records

1. Welcome Letter
2. Quick Facts

Forms to complete & return

1. AEA Membership Options
2. Enrollment Form
3. W-9
4. IDOC Terms of Agreement
5. Contact Lens Information
6. Marchon Eyewear
7. Safilo USA
8. Viva

Below are the steps to complete your IDOC membership application:

**PLEASE PRINT, COMPLETE & RETURN
THE FOLLOWING FORMS TO IDOC
ASAP!**

1. AEA Membership Options
2. Enrollment Form
3. W-9
4. IDOC Terms of Agreement
5. Contact Lens Information
6. Marchon Eyewear
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8. Viva



GET THIS PACKAGE BACK TO US!

**Mail to us:
IDOC, LLC**

5 Eversley Ave, Suite 204
Norwalk, CT 06851

OR Fax: (203) 838-4362

**OR Scan and email to
membership@idoc.net**



5 Eversley Ave.
Suite 204
Norwalk, Ct. 06851
P 203.853.3333
F 203.838.4362
www.idoc.net

Dear Doctor,

Thank you for your interest in IDOC. We are pleased to provide you with information about our highly regarded and respected practice development group of independent optometrists.

Since 1999, IDOC has been dedicated to improving the profitability of optometric practices by providing a broad range of exclusive benefits, programs and services created specifically for the independent O.D.

Through your membership with IDOC, you will receive:

- Superior buying power through vendor-partner programs
- Continuing education
- Practice management guidance
- Networking opportunities with peers and industry leaders

As an IDOC member, you will also have access to purchase from over 60 vendor-partners in a range of categories including:

- Contact lenses
- Contact lens distributors
- Optical labs
- Frame manufacturers
- Ophthalmic equipment firms
- Pharmaceuticals

These exclusive benefits can generate *tens of thousands of dollars* annually for the average practice, far in excess of traditional group purchasing methods.

Practice management tools, industry news and optometric updates are delivered through our monthly newsletters, e-mails, webcasts and our web site: www.idoc.net. IDOC conferences, provided at no cost to our members, are an additional forum for information gathering and sharing.

Our professionally staffed office is also available to answer your questions.

We can be reached at **(203) 853-3333** or e-mail: membership@idoc.net

Once again, thank you for your interest in IDOC, *the pre-eminent practice development group*. We look forward to having you join your colleagues who have experienced greater success as independent optometrists through IDOC membership.

Best regards,

Mark S. Feder, OD

President & CEO, IDOC, LLC



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QUICK FACTS

ENROLLMENT FORM:

Each practice is required to complete an IDOC Premier Membership enrollment form.

MEMBERSHIP CRITERIA:

- 1) IDOC Membership is reserved exclusively for private practice optometrists in the United States.
- 2) IDOC member must own (fully or partially) the practice they are associated with.
- 3) IDOC Member must belong to their State Optometric Association and the AOA (required by first IDOC membership renewal).

TIMING:

Annual renewal periods will be January 1 and July 1 of each year based on a member's original enrollment date. Membership fees will be prorated based on your initial enrollment date.

CONFIRMATION:

All members will receive notification confirming enrollment period and eligible benefits.

REVOCACTION:

Membership can be revoked if a member is delinquent on any IDOC accounts.

***Please remember to complete the application and get this package back to IDOC to complete the activation of your account. There are three ways to return this package to IDOC.**

Option 1-> MAIL: IDOC, LLC.
5 Eversley Ave, Suite 204
Norwalk, CT 06851

Option 2-> OR: Fax: (203) 838-4362

Option 3-> OR: Scan and email to- membership@idoc.net

MEMBERSHIP OPTIONS



Please note: Offers below available ONLY to members of the Arizona Eyecare Alliance

<u>OPTION 1</u>	<u>OPTION 2</u>
<p>Full payment = Immediate Enrollment Instant access to IDOC edge benefits</p> <p><u>Fees:</u> \$3,100 first year Annual renewal = \$1,995</p> <p><u>Check box to select:</u> <input type="checkbox"/></p>	<p>Deposit = limited access to IDOC benefits (This option will include quarterly rebates only upon full balance being paid) Complete implementation upon receipt of balance</p> <p><u>Fees:</u> \$1,000 refundable deposit \$2,100 within 60 days of enrollment</p> <p><u>Check box to select:</u> <input type="checkbox"/></p>

To complete process:

- 1) Fill out membership enrollment kit (including this form)
- 2) Check one box above
- 3) Schedule onsite visit with Signet Armorlite (SA) to implement programs and SA agreement

What Happens Next

- 1) An IDOC team member will contact you via email to inform you of receipt of your membership materials
- 2) All IDOC vendor partners will be notified of your membership within 48-hours of receipt of payment
- 3) A letter will be sent to you via U.S. Mail with your IDOC username & password. All IDOC programs & services are available on our secure website: www.idoc.net.
- 4) Reminder: You must schedule an appointment with someone to be properly set-up with Signet Armorlite pre-pay program.

Questions? We're here to help! Contact IDOC at 1-800-IDOC-409 or email us: membership@idoc.net



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ENROLLMENT FORM

Name of Doctor(s): _____ Date of Birth: __/__/_____
_____ Date of Birth: __/__/_____

Name of Practice: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (____) _____ Fax: (____) _____

E-mail: _____ Web Site: _____

AOA Membership #: _____

How did you hear about IDOC? Name: _____ Organization: _____

What type of office management software do you use? _____

Additional Locations (please use additional page for more than 3 locations)

Practice #2 Doctors Name: _____ Doctor #2 Email: _____

Name of Practice #2: _____ Telephone: (____) _____

Address: _____

City: _____ State: _____ Zip: _____

Practice #3 Doctors Name: _____ Doctor #3 Email: _____

Name of Practice #3 _____ Telephone: (____) _____

Address: _____

City: _____ State: _____ Zip: _____

Payment method:

***If paying by check, please make check payable to IDOC, LLC**

____ Paying by Check ____ Paying by Credit Card

Name on Credit Card: _____

Credit Card #: _____

Circle the Card Type: AMEX | Visa | Master Card

Exp. Date _____ Security code _____

Fill in the Amount to be paid (from previous page)

Option 1: \$ _____

Option 2: \$ _____

For credit card users- By checking this box, I hereby authorize IDOC, LLC to charge the IDOC Annual Membership fee.

***SIGN HERE->** Signature _____ Date _____

Request for Taxpayer Identification Number and Certification

Give form to the
requester. Do not
send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)	
Business name, if different from above	
Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ ----- <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
City, state, and ZIP code	
List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
: : :
or
Employer identification number
: : : : : :

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here	Signature of U.S. person ▶	Date ▶
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,



TERMS OF AGREEMENT

Membership Agreement: This contract is made and entered into, by and between IDOC, LCC, and the member who agree to the terms and conditions of membership as outlined below.

1. In the event of a change in ownership of member's practice, member is required to deliver to IDOC prior written notice of such change, at which time the existing account of member will be closed and new ownership must apply for membership. Failure to comply with this provision will result in member being responsible for any purchases made through IDOC vendor partners after the effective date of the change in ownership.
2. IDOC and member expressly acknowledge and agree that IDOC is merely acting as an intermediary between member and vendor and IDOC shall not be responsible for any defects relating to products and goods purchased from a vendor, nor for any other damages arising from, or in any way related to, member's purchase or order of merchandise from vendor, including, without limitation, any delays in shipping. IDOC hereby expressly disclaims any and all warranties, whether express or implied, relating to any such products and goods ordered from vendor, including, without limitation, the implied warranties of merchantability and fitness for a particular purpose. In addition IDOC will act as an intermediary in the collection and proper disbursement of coop funds earned from vendor partners. IDOC will not be held liable should any vendor renege on their commitment to pay coop funds.
3. Member agrees to stay current in billing with all IDOC vendor partners or risks termination of IDOC membership without refund of membership dues.
4. Each member who is a principle owner of the proprietorship, limited liability company, or corporation shall similarly abide by the terms and conditions of this agreement and by signing below.

The undersigned, as the principal owner(s) and/or executive officer(s) of member, hereby personally guarantees all of member's obligations hereunder as set forth in this agreement.

OWNER/IDOC MEMBER SIGNATURE:

PRINT NAME:

DATE:

CO-OWNER, if applicable SIGNATURE:

PRINT NAME:

DATE:



Contact Lens Account Information Form

As an IDOC Premier Member, you are eligible to participate in two major IDOC programs that can provide you with substantial financial payments from our contact lens partners, CIBA Vision & CooperVision.

In order to ensure proper tracking of your purchases, please provide us with the following account information:

Doctor Name: _____

Practice Name: _____

Practice Location: Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

CIBA Vision _____

Account #

_____ **Account Name (as it appears on CIBA Vision Invoice)**

CooperVision _____

Account #

_____ **Account Name (as it appears on CooperVision Invoice)**

Distributor:

ABB/Concise #: _____

ODG Account #: _____

Other distributors:

Name _____

Account #: _____

Name _____

Account #: _____

Name _____

Account #: _____

If you have additional locations with different account numbers, please make a copy of this form and complete the required sections.

MARCHON EYEWEAR/IDOC MEMBER AGREEMENT & COOP ADVERTISING RELEASE FORM

TO: **MARCHON EYEWEAR INC.**

Attention: Andrea Herbster (Marchon Computer Room)

DOCTOR'S NAME: _____

MARCHON ACCOUNT #: _____

PHONE: _____

ADDRESS: _____

COOP Requirements

I understand that IDOC is not a buying group, rather a doctors group which has partnered with Marchon. Marchon supports IDOC and its members, and I agree to make a commitment to support Marchon by purchasing their frames.

⇒ Annual purchases should be \$7,500 to obtain maximum discount as outlined below:

* 20% discount on non designer frames

* 10% discount on designer frames

* 2% prompt pay discount

⇒ Attempt to keep return rate under 33% for 2009

I authorize all eligible Marchon Eyewear Coop Advertising dollars earned to be sent to IDOC, LLC in lieu of any other Coop reimbursement that I would earn on an individual basis.

I hereby authorize Marchon Eyewear to utilize my accumulated Coop advertising dollars for the use of promoting IDOC, LLC until further notice.

Agreed to by: _____ **Date:** _____

Marchon Rep: _____ **Date:** _____



Partnership Program Co-op Release Form

Please select one of the following statements:

✓ I currently have a Viva account and purchase product direct from Viva. By signing below, I am agreeing to participate in the IDOC/Viva Coop program and will not be eligible for Coop funds through Viva directly.

Viva Direct Account Number: _____

✓ I currently purchase Viva product through the following buying group: _____ . By signing below, I am requesting a Viva credit application faxed to me to open a Direct Viva billing account, so I may participate in the IDOC/Viva Coop program and will not be eligible for Coop funds through Viva directly.

Practice Name: _____

Doctor Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ IDOC # _____

Fax: _____

Signature: _____

If you have any questions, contact Daisy Villacis at Viva by phone at 800.245.8482, extension 5288