THE SCHOOL BOARD OF SARASOTA COUNTY, FLORIDA

FINANCIAL SERVICES DEPARTMENT

M_E_M_O_R_A_N_D_U_M

TO: Bruce Monson, Executive Director of Financial Services

FROM: Bert Palmer, Risk Manager

DATE: August 2, 2006

SUBJECT: Group Vision Care Plan
Renewal: 01/01/2007
Carrier: Vision Care Plan (division of CompBenefits, Inc.)

The carrier has offered to renew the district group vision care insurance program at the expiring Per Employee Per Month (PEPM) rate of $4.19 for two (2) additional years [01/01/07 through 12/31/08]. The current PEPM rate has been in effect 01/01/1998 through 12/31/2006. The renewal is no increase.

The program is a collectively bargained benefit provided to all appointed employees. There will be no change in the benefit level. The average monthly district paid premium for the first seven months of the 2006 calendar year has been $24,143.33.

I recommend the district accept the proposed two (2) year renewal with no rate increase.

Attachment

compbenefits
vision
dental

1511 North Westshore Blvd., #1000
Tampa, Florida 33607
(813) 289-2020 Fax: (813) 349-5588
www.compbenefits.com

July 18, 2006

Mr. Bert Palmer
Risk Manager
The School Board of Sarasota County
1980 Landings Blvd.
Sarasota, FL 34231

Re: **207104 –** Vision Contract

Dear Mr. Palmer:

VisionCare Plan, the premier vision product of CompBenefits Corporation, agrees to renew your vision care contract for an additional twenty-four (24) months at the current plan, benefits, and rates, effective January 1, 2007.

Your plan will automatically renew thereafter for consecutive twelve (12) month periods unless terminated by either party with written notice provided sixty (60) days prior to the plan anniversary date. VisionCare Plan will provide written notice of any change in your benefits or rates one hundred and eighty (180) days prior to the plan anniversary date.

We look forward to providing for your continued vision care needs.

Sincerely,

Peter O. Collins
Assistant Vice President, Underwriting and Actuarial

cc: Belinda Gonzalez, Account Manager

Please sign below acknowledging your agreement to continue your vision care coverage as stated above.

By _____
(Authorized Signature)

Title _____ Date _____