



Vision Plan of America
(800) 400-4VPA

Employee Enrollment Form for HMO Vision Benefits

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|--|---------------|---------------------------------|---|--|
| Employer (Group) Name: | | Group No: | | |
| Applicant's Last Name: | First | Middle Initial: | <input type="checkbox"/> Active <input type="checkbox"/> Retiree | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Social Security Number: | Phone Number: | Date of Birth: (Mo/Day/Year) | Optometrist/Office #: See Provider List/Please Choose | |
| Street Address: | City: | State: | Zip: | |
| Vision Plan: <input type="checkbox"/> A (12/12/12/12) <input type="checkbox"/> B (12/12/24/12) <input type="checkbox"/> C (12/24/24/24) <input type="checkbox"/> M Plus (co pay plan) <input type="checkbox"/> Voluntary <input type="checkbox"/> Employer Paid _____% Annual Co Payment _____ | | | | |

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|--------------------------|------------------|
| COVERAGE EFFECTIVE DATE: | VPA Agent Code # |
|--------------------------|------------------|

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| Please list all eligible dependants you wish to be covered under this plan |
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| LAST NAME | FIRST | INITIAL | STUDENT (Yes / No) | M / F | DATE OF BIRTH Mo/Day/Year |
|-----------|-------|---------|-----------------------|-------|------------------------------|
| Spouse | | | | | |
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| I authorize my employer to deduct from my wages the required premium, if any, for myself and/or listed eligible dependants. This agreement shall remain in effect for a term of 12 –or - 24 months to coincide with the group application and agreement based upon plan selection, or until my employment is terminated. |
| SIGNATURE: X _____ DATE: _____ |



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3255 Wilshire Blvd #1610
Los Angeles, CA 90010
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