Vision Plan of America
(800) 400-4VPA

Employee Enrollment Form

for HMO Vision Benefits

Employer (Group) Name:		**Employer (Group) Number:**		
Last Name:	**First Name:**	**Middle Initial:**	☐ **Active** ☐ **Retiree**	☐ **Male** ☐ **Female**
Social Security Number:	**Phone Number:**	**Date of Birth:** (Mo/Day/Year)	Optometrist/Office #: **See Provider List/Please Choose**	
Street Address:	**City:**	**State:**	**Zip Code:**	

Vision Plan: ☐ **1** **(12/12/12/12)** ☐ **2** **(12/12/24/12)** ☐ **3** **(12/24/24/24)** ☐ **M-Plus** **(co pay plan)**

☐ **Voluntary** ☐ **Employer Paid** _____**%** **Annual Co Payment**_____

Coverage Effective Date:	**Waive Coverage**: (please sign)

Please list all eligible dependents you wish to have covered under this plan in the section below

LAST NAME	**FIRST NAME**	**INITIAL**	**STUDENT** (Yes / No)	**M / F**	**DATE OF BIRTH** (Mo/Day/Year)
Spouse:					
Children:					

I authorize my employer to deduct from my wages the required premium, if any, for myself and/or listed eligible dependents. This agreement shall remain in effect for a term of 12 –or - 24 months to coincide with the group contract and agreement based upon plan selection or until my employment is terminated.

SIGNATURE: X _____ **DATE:** _____

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