



insurance®
MDAPROGRAMS.COM

Enrollment form

2025 Vision Insurance

Please refer to the "Your Vision Benefit Summary" for policy details.

Please bill to: Subscriber Group

Please bill to this address: (please include city, state and ZIP):



Monthly premium			
	Exam only	Basic (Buy-up)	Premier
<input type="checkbox"/> Employee only	<input type="checkbox"/> \$2.15 monthly	<input type="checkbox"/> \$17.50 monthly	<input type="checkbox"/> \$22.50 monthly
<input type="checkbox"/> Two or more	<input type="checkbox"/> \$4.30 monthly	<input type="checkbox"/> \$38.00 monthly	<input type="checkbox"/> \$50.00 monthly
Subscriber information			
Name of employer		Effective date (1st of month)	
Subscriber last, first name, middle initial <input type="checkbox"/> Male <input type="checkbox"/> Female		DOB (month / day / year)	Social Security #
Spouse last, first name, middle initial <input type="checkbox"/> Male <input type="checkbox"/> Female		DOB (month / day / year)	Social Security #
Dependent last, first name, middle initial <input type="checkbox"/> Male <input type="checkbox"/> Female		DOB (month / day / year)	Social Security #
Dependent last, first name, middle initial <input type="checkbox"/> Male <input type="checkbox"/> Female		DOB (month / day / year)	Social Security #
Dependent last, first name, middle initial <input type="checkbox"/> Male <input type="checkbox"/> Female		DOB (month / day / year)	Social Security #
<i>By signing below, I am agreeing to be enrolled for the entire 2-year enrollment period:</i>			
Signed _____		Date _____	

Please return this enrollment form to the address or FAX below.

*Forms received by the 15th of the month will receive the first of the following month's effective date.
Billed on a quarterly basis.*