

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 #

By signing below, I am agreeing to be enrolled for the entire 2-year enrollment period:

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.*