



**ADVANTAGE VISION CARE**

**GROUP VISION CARE PLAN EMPLOYEE ENROLLMENT/CHANGE FORM**

**(PLEASE PRINT LEGIBLY)**

Change  New  Renewal  Effective Date \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Group Number assigned Plan Number 9000 Sub/Group \_\_\_\_\_

Employer Group: Group name

Date of Employment: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Plan Effective Date: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
LAST FIRST M.I.

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security # \_\_\_\_\_ MALE  FEMALE

Do you wish to cover your eligible Dependents? Yes  No  Cancel Coverage

If yes, complete the following:

Names:	Last	First	M.I.	Date of Birth	Names:	Last	First	M.I.	Date of Birth
Spouse:	_____	_____	_____	_____	Child:	_____	_____	_____	_____
Child:	_____	_____	_____	_____	Child:	_____	_____	_____	_____
Child:	_____	_____	_____	_____	Child:	_____	_____	_____	_____
Child:	_____	_____	_____	_____	Child:	_____	_____	_____	_____

**Return enrollment form and premium of \$25.50 to your Human Resource Department.**

Select Networks  
317 6<sup>th</sup> Avenue, Ste. 1040  
Des Moines, Iowa 50309

To pay for premium by Visa or MasterCard please complete this portion of application:

Cardholder \_\_\_\_\_ Account # \_\_\_\_\_

Expiration Date \_\_\_\_\_ Signature \_\_\_\_\_

Agency: