



ADVANTAGE VISION CARE

GROUP VISION CARE PLAN EMPLOYEE ENROLLMENT/CHANGE FORM

(PLEASE PRINT LEGIBLY)

Change New Renewal Effective Date _____

Group Number 60000- Plan Number 9900 Sub/Group _____

Employer Group: _____

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 **Please note: Coverage cannot be issued without premium payment.**
317 6th 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: