



**ADVANTAGE VISION CARE**

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

**(PLEASE PRINT LEGIBLY)**

CHANGE     ADD     TERM     Effective Date First of the month

Group Number 60001- Plan Number 9900 Sub/Group n/a

Employer Group: Individual/Family Membership

Date of Employment: n/a Plan Effective Date: First of the Month

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:**

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:

**NOTE: PLEASE INCLUDE YOUR EMAIL ADDRESS:** \_\_\_\_\_