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**
Spouse:				
Child:				
Child:				
Child:				

Names:	**Last**	**First**	**M.I.**	**Date of Birth**
Child:				
Child:				
Child:				
Child:				

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

Select Networks
317 6th Avenue, Ste. 1440
Des Moines, Iowa 50309

Please note: Coverage cannot be issued without premium payment.

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

Cardholder ______________________ Account # ______________________

Expiration Date ______________________ Signature ______________________

Phone Number ______________________ Email ______________________

Agency: