# *Vision Insurance Plan of America, Inc.*

## ENROLLMENT FORM

Employer:_____ Dept/Location:_____

Date of Hire:_____ Effective Date: _____

Employee Name: _____
First M.I. Last

Employee Soc. Sec. # _____-_____-_____ Sex: ☐ M ☐ F

Employee Birthdate: _____/_____/_____ Home Phone: (_____)_____

Home Address: _____

City: _____ State: _____ Zip:_____

**COVERAGE**: ☐SINGLE ☐LIMITED FAMILY (employee + spouse or employee + child or children) ☐FAMILY

**PLAN**: ☐FULL SERVICE (exam & materials) ☐MATERIALS ONLY ☐EXAM ONLY ☐WAIVE

**COVERED DEPENDENTS**

| NAME | BIRTHDATE | RELATIONSHIP | SOC. SEC. # |
|---|---|---|---|
| | / / | | - - |
| | / / | | - - |
| | / / | | - - |
| | / / | | - - |
| | / / | | - - |
| | / / | | - - |

EMPLOYEE SIGNATURE: _____ DATE:_____

**IN ORDER FOR US TO PROPERLY ENTER YOU INTO OUR COMPUTERS, WE NEED ALL INFORMATION ON THIS FORM FILLED OUT AT TIME OF ENROLLMENT. THANK YOU.**

**Vision Insurance Plan of America, Inc.**
**PO Box 44077**
**West Allis, WI 53214**
**800-883-5747 Fax:414-475-1599**