Vision Plan of America
(800) 400-4VPA

Employee Enrollment Form

for HMO Vision & Dental Benefits

California Dental Network

Employer (Group) Name:		Group No:		
Applicant's Last Name:	First	Middle Initial:	☐ Active ☐ Retiree	☐ Male ☐ Female
Social Security Number:	Phone Number:	Date of Birth: (Mo/Day/Year)	Language Preference: (Please List)	
Street Address:	City:	State:	Zip:	

Optometrist Office #:	Dentist Office #:
See Provider List or go Online to www.visionplanofamerica.com	See Provider List or go online to www.caldental.net

Vision & Dental Plan

Coverage Effective Date:	Waive Coverage: (Please sign)

Please list all eligible dependants you wish to be covered under this plan in the section below

LAST NAME	FIRST	INITIAL	STUDENT (Yes / No)	M / F	DATE OF BIRTH Mo/Day/Year
Spouse					

I authorize my employer to deduct from my wages the required premium, if any, for myself and/or listed eligible dependants. This agreement shall remain in effect for a term of 12 –or - 24 months to coincide with the group application and agreement based upon plan selection, or until my employment is terminated.

SIGNATURE: **X** _____ DATE: _____

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For Hearing Impaired Access Dial 711