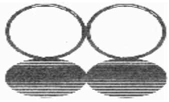

Vision Plan of America
(800) 400-4VPA

Employee Enrollment Form

for HMO Vision Benefits

Employer (Group) Name:		Employer (Group) Number:		
Last Name:	First Name:	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 Code:	

Optometrist Office #: See Provider List or go online to www.visionplanofamerica.com

Vision Plan: ☐ **A (12/12/12/12)** ☐ **B (12/12/24/12)** ☐ **C (12/24/24/24)** ☐ **M-Plus** (co pay plan)

☐ **Voluntary** ☐ **Employer Paid** __________**%** **Annual Co Payment**____________

Coverage Effective Date:	Waive Coverage: (please sign)

Please list all eligible dependents you wish to have covered under this plan in the section below

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

I authorize my employer to deduct from my wages the required premium, if any, for myself and/or listed eligible dependents. 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:** ____________________

Vision Plan of America
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Los Angeles, CA 90010
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