

VISION PLAN OF AMERICA

APPLICATION and GROUP SUBSCRIBER AGREEMENT

Plans A B C

EMPLOYER INFORMATION:

COMPANY/ORGANIZATION NAME: _____

STREET

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

BILLING

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

NAME AND TITLE OF PERSON TO WHOM BILLING IS DIRECTED: _____

DESIRED EFFECTIVE DATE

PHONE#: _____ TYPE OF BUSINESS: _____

HAS EMPLOYER FILED FOR BANKRUPTCY IN THE PAST SEVEN YEARS YES NO

EMPLOYER PAID _____%

VOLUNTARY

REMARKS: _____

AGENT OF RECORD:

NAME: _____ VPA CODE#: _____

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Code#

DO NOT WRITE IN SHADED AREAS

PLAN TYPE: _____

DEDUCTIBLE: _____

	NO. ENROLLED	RATE	TOTAL
EMPLOYEE	_____ X	\$ _____ =	\$ _____
EMPLOYEE PLUS ONE DEP.	_____ X	\$ _____ =	\$ _____
EMPLOYEE PLUS TWO OR MORE DEP.	_____ X	\$ _____ =	\$ _____

MONTHLY ADMINISTRATION FEE

\$ 10.00

FIRST MONTH'S REMITTANCE

TOTAL \$ _____

**PLEASE MAKE ALL CHECKS PAYABLE TO:
VISION PLAN OF AMERICA**

- And Mail To -
VISION PLAN OF AMERICA
3255 Wilshire Blvd., Suite 1610
Los Angeles, CA 90010

The benefits for which Subscribers and enrolled dependents are eligible under this Group Subscriber Agreement are described in Combined Evidence of Coverage/Disclosure Form ("Evidence of Coverage"), which is attached to and becomes a part of the Group Subscriber Agreement. The Evidence of Coverage includes important terms and conditions of the Group Subscriber Agreement and should be read carefully. I hereby request the coverage indicated above. This contract is covering all "A" plans for a period of twelve (12) months, and covering all "B" and "C" plans for a period of twenty-four (24) months, and will renew automatically and is subject to the terms and conditions as outlined in the Group Subscriber Agreement.

Date

BY: _____
Applicant's Authorized Representative of Corporate Office

APPROVAL:
VISION PLAN OF AMERICA
By:

ADMINISTRATOR

DATE