



Vision Plan of America  
(800) 400-4VPA

## Employee Enrollment Form

for HMO Vision & Dental Benefits



*Where Experience Makes The Difference*

Employer (Group) Name:		Employer (Group) Number:		
Last Name:	First Name:	Middle Initial:	<input type="checkbox"/> Active <input type="checkbox"/> Retiree	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security Number:	Phone Number:	Date of Birth: (Mo/Day/Year)	Language Preference: (Please List)	
Street Address:	City:	State:	Zip Code:	
Optometrist Office #: <a href="http://www.visionplanofamerica.com">See Provider List or go online to www.visionplanofamerica.com</a>		Dentist Office #: <a href="http://www.caldental.net">See Provider List or go online to www.caldental.net</a>		
Vision/Dental Plan: <input type="checkbox"/> Best Choice (M-Plus + 460) <input type="checkbox"/> Diamond (M-Plus + 495) <input type="checkbox"/> Platinum (B-2 + 495)				

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  
3255 Wilshire Blvd #1610  
Los Angeles, CA 90010  
Fax: (213) 384-0084