



Vision Plan of America
(800) 400-4VPA

Employee Enrollment Form

for HMO Vision & Dental Benefits



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 #: See Provider List or go online to www.visionplanofamerica.com		Dentist Office #: See Provider List or go online to www.caldental.net			
Vision & Dental Plan: (please select one)					
<input type="checkbox"/> Platinum (B-2 + 495) <input type="checkbox"/> Best Choice (M-Plus + 460) <input type="checkbox"/> Diamond (M-Plus + 495) <input type="checkbox"/> Emerald (A-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: _____



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