eyetopia vision care
the perfect vision solution

VISION CARE DIRECT
The vision plan your eye doctor recommends™

For Office Use Only:

Effective Date: _____

Agent of Record:

Enrollment/Change Form

Please check the appropriate box: (***Select only one box***)

☐ New Member ☐ Address Change ☐ Name Change ☐ Change in Coverage ☐ Termination

EMPLOYEE INFORMATION

Employer:_____ Approx. year of Hire _____

Social Security # _____ - _____ - _____ Date of Birth: _____ / _____ / _____

Employee: _____
Last Name First Name Middle Initial

Mailing Address: _____

City: _____State: _____ Zip: _____ Gender: Male☐ Female☐

Telephone # (_____) _____ - _____ email:_____

PRODUCT SELECTION

Enrollment	Eyetopia 120-145		Eyetopia 150/250	
Employee Only	$10.00	☐	$20.00	☐
Employee + 1	$19.00	☐	$39.00	☐
Employee & Family	$27.00	☐	$54.00	☐

PLEASE COMPLETE BELOW IF ADDING OR REMOVING DEPENDENTS

Adding	Removing	Name	Relationship	Date of Birth
☐	☐	_____	_____	_____
☐	☐	_____	_____	_____
☐	☐	_____	_____	_____
☐	☐	_____	_____	_____
☐	☐	_____	_____	_____
☐	☐	_____	_____	_____

PLEASE CHECK THE APPROPRIATE BOX

☐ I hereby authorize Eyetopia Vision Care and my employer to make the necessary changes that I have indicated on this application/change form.

☐ I hereby apply for enrollment in the Eyetopia Vision Care plan and agree to participate for a minimum of one year. I understand that canceling my membership prior to the expiration date may make me ineligible for re-enrollment and that I will be direct billed for the balance of any outstanding membership fees. I authorize my employer to deduct any required membership fees.

_____ _____
Employee Signature Date