



ADVANTAGE VISION CARE

INDIVIDUAL VISION CARE PLAN EMPLOYEE ENROLLMENT/CHANGE FORM

(PLEASE PRINT LEGIBLY)

Change New Renewal Effective Date _____

Group Number **60001-** Plan Number **9900** Sub/Group _____

Employer Group: **Individual** _____

Plan Effective Date: **1st of the month** _____

Name: _____ Date of Birth ____/____/____
LAST FIRST M.I.

Address: _____ City: _____ State: ____ Zip: _____

Social Security # _____ MALE FEMALE

Do you wish to cover your eligible Dependents? Yes No Cancel Coverage

If yes, complete the following:

Names:	Last	First	M.I.	Date of Birth	Names:	Last	First	M.I.	Date of Birth
Spouse:	_____	_____	_____	_____	Child:	_____	_____	_____	_____
Child:	_____	_____	_____	_____	Child:	_____	_____	_____	_____
Child:	_____	_____	_____	_____	Child:	_____	_____	_____	_____
Child:	_____	_____	_____	_____	Child:	_____	_____	_____	_____

Return enrollment form and premium of \$25.50 to:

Select Networks
317 6th Avenue, Ste. 1440
Des Moines, Iowa 50309-4109

Agent/Agency: _____

To pay for premium by Visa or MasterCard please complete this portion of application:

Cardholder _____ Account # _____
Expiration Date _____ Signature _____
Phone Number _____ Email _____