Voluntary Vision **Enrollment Application**	**Employer Name**	----------
	Effective Date	**Month / Year**
	Coverage Selected	**Please circle** **Single / 2-Person / Family**

Employee Information

Last Name	**First Name**		**Middle**	
Home Address	**City**		**State**	**Zipe Code**
Social Security #	**Telephone #**	**Male**	**Female**	**Date of Birth**

Are you or your spouse covered by another VISION plan? Yes/No
If YES, Name of VISION insurer or plan:

Once enrolled, members will not be able to cancel vision coverage until the open enrollment period or if employee terminates with the company. Once cancelled, employees will not be able to rejoin for a period of 2 years.

Dependent Information

First	Middle Initial	Sex Male/Female	Date of Birth Month / Day / Year
Spouse			
1			
Children			
2.			
3.			
4.			
5.			
6.			

YOUR signature signifies that you have verified the information contained herin.

Plan Administrator:
SVS VISION
140 Macomb
Mt. Clemens, MI 48043
Phone: (586) 468-7370
Fax: (586) 468-7682

Signature _____

Date _____

Mail or Fax completed enrollment form to the plan administrator and keep a copy for your records.

FOR OFFICE USE ONLY	**Group #**	**BENEFIT CODE**