Vision Insurance
Pre Enrollment Information Form

Personal Information:

Name: ____________________ SS# ____________________

Date of Birth: ____________ Male: ____________ Female: ____________

Address: ____

Depenents: ____________ Single or Married: ____________

Email: ____________ Height: ____________ Weight: ____________

Have you had Dental coverage within the last 90 days? ____________

Dependent Information If Adding To Your Plan:

Spouse: ____________ Male/Female: ____________ DOB: ____________

Child 1: ____________ Male/Female: ____________ DOB: ____________

Child 2: ____________ Male/Female: ____________ DOB: ____________

Child 3: ____________ Male/Female: ____________ DOB: ____________

Plan Options:

Premiums are based on individual, zip code and date of birth. More for additional individuals.

	Plan 1	Plan 2	Plan 3
Deductible	None	None	None
Eye Exam Copay	$20	$15	$10
Standard Lens Copay	$25	$20	$10
Frame Allowance	$130	$160	$200
Contact Lens Allowance	$130	$160	$200
Progressive Copay	$90	$85	$10
Standard Lens:			
Polycarbonate	$40	$40	$0
Scratch Resistant	$15	$15	$0
Anti-glare	$45	$45	$45
UV Protection	$15	$15	$15
Tinted Lens	$15	$15	$15
Light to dark tinting	$75	$75	$75
Out of Network	Included	Included	Included
Premium	$10-$12	$13-$15	$18-$20

Select Plan $ ________ $ ________ $ ________

Accident Insurance
Pre Enrollment Information Form

Personal Information:

Name: ______________________ SS# ______________________

Date of Birth: ______________ Male: ______________ Female: ______________

Address: ______________________________ Contact # ______________

Depenents: ______________ Single or Married: ______________

DL #: ______________ Height: ______________ Weight: ______________

Email: ______________________ Company: ______________

Job Title: ______________ Monthly Income: ______________

Tabacco User: ______________ Hours work per week: ______________

Dependent Information:

Spouse: ______________ Male/Female: ______________ DOB: ______________

Child 1: ______________ Male/Female: ______________ DOB: ______________

Child 2: ______________ Male/Female: ______________ DOB: ______________

Child 3: ______________ Male/Female: ______________ DOB: ______________

Beneficiary Information:

Name: ______________ Male/Female: ______________ DOB: ______________

Name: ______________ Male/Female: ______________ DOB: ______________

Name: ______________ Male/Female: ______________ DOB: ______________

Additional Benefit Options:

Check the boxes to add additional benefits and at the bottom, circle the beneft to add to this plan:

☐ Income Protector	Just Me	Me & Spouse	Me & Children	Family
☐ Critical Illness	Just Me	Me & Spouse	Me & Children	Family
☐ Hospital Indemnity	Just Me	Me & Spouse	Me & Children	Family
☐ TeleMedicine	Just Me	Me & Spouse	Me & Children	Family
☐ Term Life	Just Me	Me & Spouse	Me & Children	Family

Recurring ACH Payment Authorization

You authorize regularly scheduled charges to your checking/savings account. You will be charged the amount indicated below each billing period. A receipt for each payment will be provided to you and the charge will appear on your bank statement as an "ACH Debit". You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

I ________________________ authorize __________________________ to charge my
(Full Name) (Merchant's Name)

bank account indicated below for $________________ on the ________________ of
(Amount $) (day)

each ________________.
(week, month, etc.)

This payment is for __________________________________.
(Description of Goods/Services)

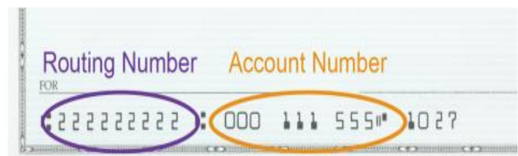
Billing Information

Billing Address ____________________________ Phone # _______________________

City, State, Zip ____________________________ Email _________________________

Bank Details

☐ Checking ☐ Savings



Account Name __________________________
Bank Name __________________________
Account Number __________________________
Routing Number __________________________

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify ______________ in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that _________________ may at its discretion attempt to process the charge again within 30 days, and agree to an additional $_________________ charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this bank account and will not dispute these scheduled transactions with my bank; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE ____________________________ DATE ______________________
(Account Holder's Signature)