OPTIPLUS VISION PLAN

A PGP Voluntary Vision Program

EMPLOYEE ENROLLMENT APPLICATION

Company Name_____ Policy #_____

Effective Date _____ *Note: Effective Date of Coverage Must be the First Day of the Month.*

EMPLOYEE INFORMATION

Last Name _____ First Name _____ Initial_____

Address _____ City _____ State_____ Zip_____

Home Phone Number (_____)_____Work Phone Number (_____)_____

Social Security # _____/_____/_____ D.O.B. _____/_____/_____ Sex M____ F____ Date Employed ____/____/____

COVERAGE REQUESTED

☐ Single - $9.60 ☐ *Two Party - $15.25 ☐ *Family - $23.83

*If Selecting Two Party or Family Coverage Complete Dependent Information Below.

☐ I authorize a payroll deduction in the amount of $_____a month for GVS Vision Program

DEPENDENT INFORMATION

Name Of Spouse And Unmarried Dependents	CHECK RELATIONSHIP			BIRTH DATE		
	Spouse	Son	Daughter	Month	Date	Year

Employee Signature **X** _____ Date: ____/____/_____

Employer Signature **X** _____ Date: ____/ ____/ ____

IMPORTANT **Please Type Or Write Application Neatly. Any Missing Information Will Delay Processing Your Application**

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