mda insurance®
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Enrollment form

2024 Vision Insurance

Please refer to the "Your Vision Benefit Summary" for policy details.

Please bill to: ❑ Subscriber ❑ Group

Please bill to this address: (please include city, state and ZIP):

_____

_____

Monthly premium

	Exam only	Basic (Buy-up)	Premier
❑ Employee only	❑ $2.15 monthly	❑ $17.50 monthly	❑ $22.50 monthly
❑ Two or more	❑ $4.30 monthly	❑ $38.00 monthly	❑ $50.00 monthly

Subscriber information

Name of employer	Effective date (1st of month)	
Subscriber last, first name, middle initial ❑ Male ❑ Female	DOB (month / day / year)	Social Security #
Spouse last, first name, middle initial ❑ Male ❑ Female	DOB (month / day / year)	Social Security #
Dependent last, first name, middle initial ❑ Male ❑ Female	DOB (month / day / year)	Social Security #
Dependent last, first name, middle initial ❑ Male ❑ Female	DOB (month / day / year)	Social Security #
Dependent last, first name, middle initial ❑ Male ❑ Female	DOB (month / day / year)	Social Security #

By signing below, I am agreeing to be enrolled for the entire 2-year enrollment period:

Signed _____ Date _____

Please return this enrollment form to the address or FAX below.
Forms received by the 15th of the month will receive the first of the following month's effective date.
Billed on a quarterly basis.

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