mda insurance®
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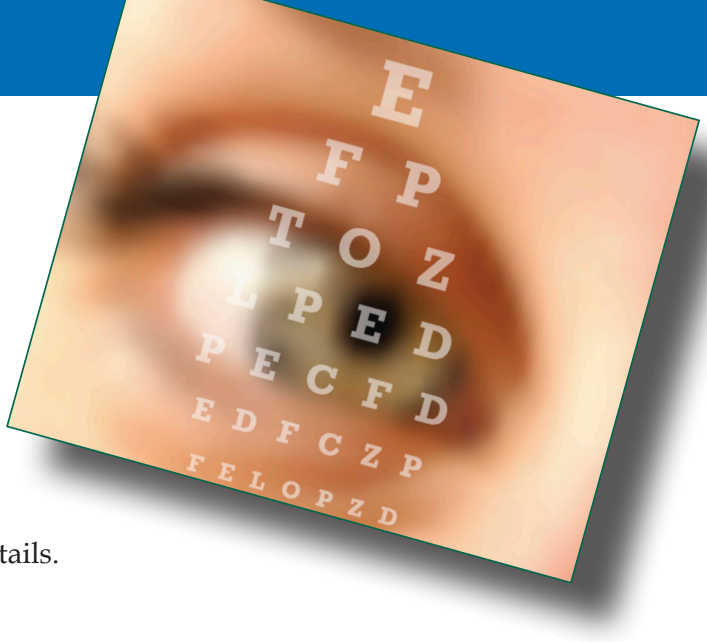

Enrollment form

2020 Vision Insurance

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

Please bill to: ❑ Subscriber ❑ Group

Monthly premium

	Exam only	Basic (Buy-up)	Premier
❑ Employee only	❑ $2.05 monthly	❑ $16.50 monthly	❑ $21.50 monthly
❑ Two or more	❑ $4.10 monthly	❑ $36.00 monthly	❑ $47.00 monthly

Subscriber information

Name of employer		
Subscriber's Social Security Number	Date of birth (month / day / year)	
Subscriber last, first name, middle initial ❑ Male ❑ Female	Effective date (1st of month)	
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 #
Home address *(please include city, state and ZIP)*		
Billing address *(if different than home, please include city, state and ZIP)*		

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.

3657 Okemos Road, Suite 100 • Okemos, MI 48864 877.906.9924 • mdaprograms.com • FAX 517.484.5460