



BLOCK VISION OF TEXAS, INC.
 6737 West Washington Street, Suite
 2202
 Milwaukee, Wisconsin 53214

ENROLLMENT/CHANGE FORM

Initial Enrollment (Print and complete all sections) Change (print employer name, enrollee name and SSN and all changes)
 Please print and complete all sections. See instructions below.

EMPLOYER/EMPLOYEE INFORMATION					
Employer Name City of Glenn Heights		Group Number 321420	Location	Effective Date	Date of Hire
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (Employee or subscriber)	First Name	M.I.	Date of Birth (DOB)	Social Security Number (SSN)
Home Street Address		City/State/Zip	Home Phone		Work Phone

FAMILY INFORMATION (Only those eligible may be enrolled.)				
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (spouse)	First Name	M.I.	DOB & SSN
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	DOB & SSN
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	DOB & SSN
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	DOB & SSN
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	DOB & SSN
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	DOB & SSN

Do you or any of your dependents have other vision coverage? Yes No
 If yes, please give: Policyholder _____ Health Care Carrier _____
 Employee Signature: _____ Date: _____

Please indicate your primary language _____
 Do you have a disability affecting communication or reading? No Yes If yes, please specify _____

I elect the following vision coverage: <input type="checkbox"/> Employee only \$ _____ <input type="checkbox"/> Employee + spouse \$ _____ <input type="checkbox"/> Employee + child(ren) \$ _____ <input type="checkbox"/> Family \$ _____ <input type="checkbox"/> Waived	Plan Type: <input type="checkbox"/> Full service (exam and eyewear)
Declination of coverage must be accompanied by the employee's signature above.	
I am aware of and accept the following coverage conditions: 1. I (we) authorize the use of my (our) medical records for the quality assurance program conducted by Block Vision or its designees, as permitted by law. A copy of this authorization will be valid as the original. 2. I (we) will abide by the terms of the contract in which I (we) enrolled. 3. I (we) will cooperate as required by the Coordination of Benefits procedures.	