Avēsis
INCORPORATED

ADVANTAGE VISION CARE

GROUP VISION CARE PLAN EMPLOYEE ENROLLMENT/CHANGE FORM

(PLEASE PRINT LEGIBLY)

Change ☐ New ☐ Renewal ☐ Effective Date _____

Group Number **60000-1066** Plan Number **9900** Sub/Group _____

Employer Group: **Collins -Maxwell Schools**

Date of Employment: / / Plan Effective Date: **July 1**

Employee Name: _____ Date of Birth / /
LAST FIRST M.I.

Address: _____ City: _____ State: ____ Zip: _____

Social Security # _____ MALE ☐ FEMALE ☐

Do you wish to cover your eligible Dependents? **Yes** ☐ **No** ☐ **Cancel Coverage** ☐

If yes, complete the following:

Names:	**Last**	**First**	**M.I.**	**Date of Birth**	**Names:**	**Last**	**First**	**M.I.**	**Date of Birth**
Spouse:					Child:				
Child:					Child:				
Child:					Child:				
Child:					Child:				

Return enrollment form and premium of $25.50 to your Human Resource Department.

Select Networks
317 6th Avenue, Ste. 1040
Des Moines, Iowa 50309

Please note: Coverage cannot be issued without premium payment.

To pay for premium by Visa or MasterCard please complete this portion of application:

Cardholder _____ Account # _____

Expiration Date _____ Signature _____

Agency: