

VisionChoice[®]

Provider Nomination Form

Please complete this form if you wish to recommend a provider for participation in the VisionChoice[®] program. You may mail, e-mail or fax your completed nomination form to:

Southland National Insurance Corporation
Vision Provider Relations/Network Development
Attn: Joanna Jungen
1812 University Blvd
Tuscaloosa, Alabama 35401
Fax: (205) 343-1239
E-mail: jjungen@southlandnational.com

Your Name: _____	Date: _____	
Your Company: _____		
Name of Provider: _____		
<input type="checkbox"/> Ophthalmologist (MD)	<input type="checkbox"/> Optometrist (OD)	<input type="checkbox"/> Optician or Optical Store
Street: _____		
City: _____	State: _____	Zip Code: _____
Telephone: _____	Fax: _____	

Please note that every effort will be made to consider your nomination. However, geographical location and VisionChoice[®]'s qualifying guidelines may restrict provider participation.