

# VisionChoice® Group Information Sheet

PLEASE PRINT OR TYPE

Name of Group: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Street Address (if different from above): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Nature of Business: \_\_\_\_\_ Industry Code: \_\_\_\_\_

Telephone: (     ) \_\_\_\_\_ Fax: (     ) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Payroll Administrator: \_\_\_\_\_ Telephone: (     ) \_\_\_\_\_

Total Eligible Subscribers: \_\_\_\_\_ Number of Subscribers Enrolled: \_\_\_\_\_

Check:  Voluntary  Employer/Group Paid Employer/Group pays: \_\_\_\_\_ % of Access Fees.

Monthly access fee for single is: \_\_\_\_\_ Monthly access fee for family is: \_\_\_\_\_

**Participation Billing Requirements:** (The group must have 3 or more participants. The total fees for the first month must be sent in with the group's enrollment forms.)

**Eligibility:** Waiting Period For New Subscribers \_\_\_\_\_  
(All eligible subscribers become effective on the first of the month following the waiting period.)

The undersigned agrees to administer the program and to make payment as applicable.

\_\_\_\_\_  
Authorized Signature Title Date

\_\_\_\_\_  
Agent's Signature Date

Southland Benefit Solutions

By: \_\_\_\_\_ Date \_\_\_\_\_