APPLICATION

Professional Eye Associates of Central Illinois, LLC

"CHOICE" Vision Care Plans

Application for "Choice" Vision Care Benefits

I. EMPLOYER INFORMATION

Name of Employer: ____

DBA (If other than above): ____

Tax I.D. #: ______________________ Type of Business:_____________________________
(Sole Proprietorship, Corporation, Partnership, Other (specify)

Contact Person: ____
(H.R. or Benefit Coordinator)

Business Address: ____ Zip Code: _________

Mailing Address (If other than above): ____

Telephone: (_______) _________________ Fax: (_______)_________________

Requested Coverage Effective Date: _____________________, 20____

No. of Employees Enrolled in this Plan: __________

II. PLAN SELECTION

Discount Vision Care Plan With Refractive Surgery Component, Other Services Access

III. ELIGIBILITY

All full-time and part-time employees under the age of 65 are eligible to participate in "Choice" Vision Care Plan. All spouses of eligible employees, as well as eligible dependent children who are under the age of 23 years may participate.

IV. EFFECTIVE DATES OF ENROLLMENT

Effective:________________, 20_____ through ________________, 20_____

The Employer agrees to maintain and furnish any records necessary to administer the Plan. The Employer certifies that all information shown in this application and any attachments thereto is correct and complete. Any omission or inaccuracy of pertinent information will delay eligibility for benefits under this plan.

Signed: _________________________ Date: ___________________

Witness: ________________________ Date: ___________________