Vision Application

HUMAN CAPITAL
A **Vensure Employer Services** Company

Section 1: Employee Information		
On-Site Employer:		
Subscriber Name (Last):	Subscriber Name (First):	(M.I.):
Street Address:		
City:	State:	ZIP Code:
Social Security Number:	Date of Birth:	Gender: ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married	Home Phone:	Work Phone:

Dependent Legal Name	Gender	Relation	Date of Birth	Social Security Number

Section 2: Coverage Election	VSP Plan B	VSP Plan C
Employee	☐ $8.09	☐ $9.98
Two Party	☐ $12.35	☐ $15.23
Family	☐ $22.15	☐ $27.32

Please Note: Rates Shown are ***Monthly.***

For more information, please call: 248.353.344.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. By signing this I certify that the information on this form is correct.

Signature of Subscriber

Date

For Internal Use Only:				
☐ Carrier	☐ Prism	DOH:	Effective Date:	HR:

@2019 Human Capital