BLOCK VISION OF TEXAS, INC.
120 West Fayette Street, Suite 700
Baltimore, Maryland 21201

ENROLLMENT/CHANGE FORM

☐ Initial Enrollment (Print and complete all sections) ☐ Change (print employer name, enrollee name and SSN and all changes)

Please print and complete all sections. See instructions below.

EMPLOYER/EMPLOYEE INFORMATION					
Employer Name **SABINE ISD**		**Group Number** **320170**	**Location**	**Effective Date**	**Date of Hire**
Sex ☐ M ☐ F	**Last Name (Employee or subscriber)**	**First Name**	**M.I.**	**Date of Birth (DOB)**	**Social Security Number (SSN)**
Home Street Address	**City/State/Zip**		**Home Phone**		**Work Phone**

FAMILY INFORMATION (Only those eligible may be enrolled.)				
Sex ☐ M ☐ F	**Last Name (spouse)**	**First Name**	**M.I.**	**DOB & SSN**
Sex ☐ M ☐ F	**Last Name (dependent)**	**First Name**	**M.I.**	**DOB & SSN**
Sex ☐ M ☐ F	**Last Name (dependent)**	**First Name**	**M.I.**	**DOB & SSN**
Sex ☐ M ☐ F	**Last Name (dependent)**	**First Name**	**M.I.**	**DOB & SSN**
Sex ☐ M ☐ F	**Last Name (dependent)**	**First Name**	**M.I.**	**DOB & SSN**
Sex ☐ M ☐ F	**Last Name (dependent)**	**First Name**	**M.I.**	**DOB & SSN**

Do you or any of your dependents have other vision coverage? ☐ Yes ☐ No

If yes, please give: Policyholder _____Health Care Carrier _____

Employee Signature: _____ Date: _____

Please indicate your primary language _____

Do you have a disability affecting communication or reading? ☐ No ☐ Yes If yes, please specify _____

I elect the following vision coverage:

- ☐ Employee only $_____
- ☐ Employee + 1 $_____
- ☐ Family $_____
- ☐ Waived

Plan Type:

☐ Full service (exam and eyewear)

Declination of coverage must be accompanied by the employee's signature above.

I am aware of and accept the following coverage conditions:

1. I (we) authorize the use of my (our) medical records for the quality assurance program conducted by Block Vision or its designees, as permitted by law. A copy of this authorization will be valid as the original.
2. I (we) will abide by the terms of the contract in which I (we) enrolled.
3. I (we) will cooperate as required by the Coordination of Benefits procedures.