



**BLOCK VISION OF TEXAS, INC.**  
**6737 West Washington Street, Suite 2202**  
**Milwaukee, Wisconsin 53214**

**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 <b>Spring Hill ISD</b>		Group Number <b>325700</b>	Location	Effective Date	Date of Hire
Sex <input type="checkbox"/> M <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (spouse)	First Name	M.I.	DOB & SSN
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	DOB & SSN
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	DOB & SSN
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	DOB & SSN
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	DOB & SSN
Sex <input type="checkbox"/> M <input type="checkbox"/> 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 + spouse \$ \_\_\_\_\_
- Employee + child(ren) \$ \_\_\_\_\_
- 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.