APPLICANT INFORMATION

avēsis ESSENTIAL BENEFITS
VISION CARE PLAN

Member Name:

Address:

City: State, ZIP:

Phone: E-mail:

Date of Birth: SS#:

Gender: ☐ Male ☐ Female

Do you wish to cover eligible dependents? ☐ Yes ☐ No

	NAME:	DATE OF BIRTH:
Spouse:		
Child:		
Child:		
Child:		

SELECT YOUR COVERAGE & PAYMENT OPTIONS

Effective Date:

Desired Coverage: ☐ Member ☐ Member + 1 ☐ Member + Family

Pay: **Annually via:** ☐ Credit Card ☐ Check

Monthly via: ☐ Credit Card ☐ Bank Draft (Attached voided check)

Credit Card #:

Card Holder Name:

Expiration Date:

COVERAGE OPTIONS AND RATES

Coverage Type	Monthly Rate	One time set up fee
Member	$10.90	$20.00
Member + 1	$19.08	$20.00
Member + Family	$28.37	$20.00

Effective Date	Member	Member + 1	Member + Family
5/1/2017	$130.80	$228.96	$340.44
6/1/2017	$119.90	$209.88	$312.07
7/1/2017	$109.00	$190.80	$283.70
8/1/2017	$98.10	$171.72	$255.33
9/1/2017	$87.20	$152.64	$226.96
10/1/2017	$76.30	$133.56	$198.59
11/1/2017	$65.40	$114.48	$170.22
12/1/2017	$54.50	$95.40	$141.85
1/1/2018	$43.60	$76.32	$113.48
2/1/2018	$32.70	$57.24	$85.11
3/1/2018	$21.80	$38.16	$56.74
4/1/2018	$10.90	$19.08	$28.37

There is an additional one time set up fee of $20.00.

AIP
ASSOCIATION OF INSURANCE PROFESSIONALS
8430 Enterprise Circle, Suite 200 • Lakewood Ranch, FL 34202
PHONE: (800) 411-4753 • **FAX:** (800) 411-4771

Group Number: 20790-1159 • **Plan Number:** 924

I hereby apply for coverage under the AIP vision plan for which I am entitled to participate. I authorize the deduction(s) as indicated above. I agree that once enrolled I will remain enrolled during the designated plan period, and that future renewals will be automatic unless I inform AIP in writing.

Member Signature: Date: