American Optical Plan Enrollment Form

Name_____
LAST *FIRST* *M.I.*

_____
STREET *APT. #*

AZ
CITY *ZIP*

_____
DAYTIME PHONE *DATE OF BIRTH*

AGENT_____

PLEASE SEND INFO : ❑ DENTAL PLAN ❑ CHIROPRACTIC PLAN
❑ HOSPITAL/MEDICAL/PHARMACY

MAKE CHECK PAYABLE TO: **AMERICAN OPTICAL PLAN**
P.O. BOX 44227
PHOENIX, AZ 85064-4227

ANNUAL MEMBERSHIP DUES

	1 YEAR	*2 YEARS*
INDIVIDUAL	☐ $ 15.00	☐ $25.00
2 PERSONS	☐ $ 22.00	☐ $35.00
ENTIRE FAMILY...	☐ $ 29.00	☐ $49.00

SPOUSE_____

CHILDREN & BIRTHDATES_____

_____

_____

MEMBERS AGREE TO ALL TERMS OF MEMBERSHIP