eyetopia
the perfect vision solution

Agency: FFGA
Agent of Record: Zac Pruitt

Enrollment/Change Form

Effective Date
(1st of the month): _____

Please check the appropriate box: (***Select only one box***)

☐ New Member ☐ Address Change ☐ Name Change ☐ Change in Coverage ☐ Termination

EMPLOYEE INFORMATION

Employer: Lubbock ISD Year of Hire: _____

Employee: _____
First Name Middle Last Name

Gender: M F Date of Birth: _____ / _____ / _____ Phone: _____

Alternate Phone: _____ E-mail: _____
(Used as your login to Eyetopia.org)

Social Security# _____ - _____ - _____ (Optional based on your Employer's record tracking requirements.)

Main Address: _____ City, ST Zip _____

*Alternate Address (Mailing or Student): _____ City ST Zip _____

PRODUCT SELECTION

Enrollment	Eyetopia Standard 120/145		Eyetopia Gold 150/250	
Employee Only	$8.50	☐	$20.00	☐
Employee + 1	$16.50	☐	$37.00	☐
Emp + Children	$17.00	☐	$42.00	☐
Family	$24.00	☐	$52.00	☐

PLEASE COMPLETE BELOW IF ADDING OR REMOVING DEPENDENTS *(Note alternate address option)*

Add	Remove	First	Middle	Last	Gender	Date of Birth	Relationship	*Alt Address
☐	☐							☐
☐	☐							☐
☐	☐							☐
☐	☐							☐
☐	☐							☐

PLEASE CHECK THE APPROPRIATE BOX *(please check **one** of the boxes below)*

If making a change, terminating, or adding/removing dependents check here

☐ I hereby authorize Eyetopia Vision Care and my employer to make the necessary changes that I have indicated on this application/change form.

If enrolling in the plan check here

☐ I hereby apply for enrollment in the Eyetopia Vision Care plan and agree to participate for a minimum of one year. I understand that canceling my membership prior to the expiration date may make me ineligible for re-enrollment and that I will be direct billed for the balance of any outstanding membership fees. I authorize my employer to deduct any required membership fees.

_____ _____
Employee Signature Date