



PREFERRED VISION SERVICES, INC.

91 East Maple Road • Troy, Michigan 48083 • (248) 524-9581 • Fax (248) 524-9429

Request Card

Employer Name _____
(Please Print or Type)

Employee's Name	_____	_____	_____	_____	_____	_____	_____	_____
	Last	First	Middle	Social Security No.			Year Born	
Home Address	_____			_____	_____	_____	_____	_____
	Street		City	State	Zip	Phone		

Complete a Request Card for Each Person Who Needs Vision Care at This Time

Benefits Requested for (Check ONLY One)

Myself _____

Spouse _____

or _____

Child _____

{ Name _____
 Relationship _____ Year Born _____

IMPORTANT: Mail Request Card BEFORE You Make Eye Care Appointment.
PVS Will Send You Benefit Form and List of Doctors.

**PREFERRED
VISION
SERVICES, INC.**

91 EAST MAPLE ROAD
TROY, MICHIGAN 48083
Telephone (248) 524-9581 • Fax (248) 524-9429
 NEW ENROLLMENT CHANGE

GROUP #	
DIVISION #	CERT. #

NAME _____
LAST NAME FIRST NAME MIDDLE INITIAL MAIDEN NAME

ADDRESS _____
NUMBER STREET CITY STATE ZIP CODE

NAME OF EMPLOYER _____

DATE OF BIRTH	MO. / DAY / YR	SOCIAL SECURITY NUMBER	SEX	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED
DATE OF HIRE (FULL TIME)	MO. / DAY / YR	COVERAGE CLASS		
# HOURS PER WEEK	OCCUPATION:			



LIST NAMES OF DEPENDENTS TO BE COVERED:	RELATIONSHIP	AGE	DATE OF BIRTH MO. DAY YR
	SPOUSE		

EMPLOYER OF SPOUSE
EMPLOYER'S VISION COMPANY, IF APPLICABLE

DATE: _____ EMPLOYEE SIGNATURE _____