AMERICA'S BEST
VISION PLAN

Enrollment Form

Name_____

DOB_____ **Enrollment Date** _____

Address_____

Phone: Home_____ Cell_____

Email_____

ENROLLMENT: I want to become a Member of America's Best Vision Plan under the plan checked below, effective on the Enrollment Date. My annual, one-time membership fee is listed for each plan (does not include co-payments).

☐ Two Pair plus Eye Exam - $69.95 ☐ Three Year Contact Lens Exams - $99.00

☐ I have paid/will pay the Membership Fee to access my plan benefits.

☐ I agree to accept electronic delivery of my Membership Contract, which describes fully my Membership terms. I understand I can obtain that electronic copy at www.abvisionplan.com. If I have questions or want to receive a paper copy, I can call (800) 841-2790.

Signature X_____