



**ALLIANCE FOR
SMALL
BUSINESS**

ALLIANCE FOR SMALL BUSINESS

Vision Membership Application With Special Voucher

\$64.95 per year / INCLUDES ONE \$35.00 Eye Exam Reimbursement Voucher

ID# _____ (office use only) Effective Date _____

Last Name		First Name		SS#		DOB		
Address			City			State		Zip
Signature						Date		

DEPENDENTS

Last Name	First	MI	DOB	SS#	M / F
Last Name	First	MI	DOB	SS#	M / F
Last Name	First	MI	DOB	SS#	M / F
Last Name	First	MI	DOB	SS#	M / F
Last Name	First	MI	DOB	SS#	M / F

Special \$35.00 Reimbursement Voucher

Last Name		First Name		M.I.	Email	
Date of Eye Exam		Physicians Name (Or name of eye clinic)				
Signature					Date	

Must Submit completed, signed copy of this application and voucher form with a copy of the paid eye exam invoice showing yourself or one of your listed dependents as recipient of the eye exam. Must schedule your eye exam within the first 6 months from your effective date on the application. All effective dates will be the 1st of the month following the application signature date. Allow 4-6 weeks for processing and only one \$35.00 voucher per application can be submitted and reimbursed and must be received within 30 days after the six month benefit period effective date. Program discounts are valid for all family members and may be used as often as necessary. Enjoy your savings!

Mail To: P.O. Box 101807 Fort Worth, Texas 76185