PEP EMPLOYER Enrollment Request

Name of Company / Organization

Company Contact Name

Address / City / State / Zip

Phone

Fax

Email Address

Number of Full-Time Employees

Number of Part-Time Employees

Health and/or vision insurance plans your company participates in, if any

How will PEP information / cards be distributed to your employees?

Would company be interested in corporate vision screenings? ◯ Yes ◯ No

Would company be interested in LASIK/Refractive Seminars? ◯ Yes ◯ No

I am the person responsible for insurance programs and employee benefits at the company named above. I request that this company be enrolled in the Progressive Eye Plan. I understand that enrollment in this plan may be terminated at any point by either the company or by the PEP administrators. As company representative, I understand that it is my responsibility to distribute PEP information and cards to all employees in this company and will request more cards and/or information as they are needed.

Company Representative Signature

Date

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HELPING YOU SEE YOUR WORLD

mcpeakvision.com

For more details on PEP Membership:
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