



**VISION SERVICE PLAN
ENROLLMENT FORM
MICHIGAN OSTEOPATHIC ASSOCIATION**

Member Name: _____
Last Name, First Name, Middle Initial

Member Address: _____

Member Social Security Number: _____

Gender: _____ Male _____ Female **Date of Birth:** _____

Phone Number _____

Spouse Name _____ **Date of Birth** _____

Dependent Name _____ **Date of Birth** _____

Dependent Name _____ **Date of Birth** _____

Dependent Name _____ **Date of Birth** _____

Premiums: **Member** **\$16.03**
 Member + one dependant **\$24.48**
 Member and family **\$43.90**

Member Signature

Date

*Please return this form to your MOA benefits administrator. Do not return to VSP.
Fax to MOA at 517-347-1566 Or
Mail to: MOA Insurance Department
2445 Woodlake Circle
Okemos, MI 48864*