

APPLICANT INFORMATION



Member Name:

Address:

City:

State, ZIP:

Phone:

E-mail:

Date of Birth:

SS#:

Gender: Male Female

Do you wish to cover eligible dependents? Yes No

NAME:

DATE OF BIRTH:

Spouse:

Child:

Child:

Child:

SELECT YOUR COVERAGE & PAYMENT OPTIONS

Effective Date:

Desired Coverage: Member Member +1 Member +Family

Pay: **Annually via:** Credit Card Check

Monthly via: Credit Card Bank Draft (Attached voided check)

Credit Card #:

Card Holder Name:

Expiration Date:

I hereby apply for coverage under the AIP vision plan for which I am entitled to participate. I authorize the deduction(s) as indicated above. I agree that once enrolled I will remain enrolled during the designated plan period, and that future renewals will be automatic unless I inform AIP in writing.

Member Signature:

Date:

COVERAGE OPTIONS AND RATES

COVERAGE TYPE	MONTHLY RATE	SET UP FEE
Member	\$8.02	\$20.00
Member + 1	\$14.04	\$20.00
Member + Family	\$20.86	\$20.00

EFFECTIVE DATE	MEMBER	MEMBER + 1	MEMBER + FAMILY
5/1/2009	\$116.24	\$188.48	\$270.32
6/1/2009	\$108.22	\$174.44	\$249.46
7/1/2009	\$100.20	\$160.40	\$228.60
8/1/2009	\$92.18	\$146.36	\$207.74
9/1/2009	\$84.16	\$132.32	\$186.88
10/1/2009	\$76.14	\$118.28	\$166.02
11/1/2009	\$68.12	\$104.24	\$145.16
12/1/2009	\$60.10	\$90.20	\$124.30
1/1/2010	\$52.08	\$76.16	\$103.44
2/1/2010	\$44.06	\$62.12	\$82.58
3/1/2010	\$36.04	\$48.08	\$61.72
4/1/2010	\$28.02	\$34.04	\$40.86

Includes a \$20 administrative fee.



ASSOCIATION OF
INSURANCE PROFESSIONALS

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Group Number: 20790-1159 • **Plan Number:** 924