

Mountain Vision Plan

Membership Enrollment Form

Two Year Plan

Employer (if applicable): _____

Employee/Member: _____
Last Name First Initial

Address: _____

Date of Birth: ____/____/____ Social Security # ____ - ____ - ____ Male Female

Telephone: _____

Coverage Selection: (Check one) Single Single + 1 Family

Family Members	Relationship	Date of Birth	Gender
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I hereby apply for enrollment in Mountain Vision Plan for a minimum of two years or unless I have a qualified change in family status.

Member Signature

Date

Administered by:
REDS Administration
25 North 8th Street, Suite 1
Lewisburg, PA 17837
1-888-515-1573

Sponsored by:

INSURANCE
COORDINATORS
OF MONTANA INC.