Prevent Blindness Georgia®
Our Vision Is Vision®
an affiliate of Prevent Blindness America

Suite 200
739 West Peachtree Street
Atlanta, GA 30308-1137
(404) 266-2020
(404) 266-0860 Fax
toll free (800) 477-4448

APPLICATION FOR VISION SERVICE PLAN BENEFITS

Applicant Information

Name: _____ Date of: Birth: _____

Address: _____

_____ Social Security #:_____-_____-_____

City:_____ State: _____ Zip: _____ Phone: (____) _____-_____

Eligible for Medicaid or other vision insurance? [ ]Yes [ ] No

U.S. citizen? [ ]Yes [ ]No Resident Alien? [ ] Yes [ ] No High school graduate? [ ] Yes [ ] No

Parent/Guardian Information

Name: _____ Relation to Applicant: _____

Address: _____

_____ Social Security #:_____-_____-_____

City:_____ State: _____ Zip: _____

Home Phone: (____) _____-_____ Work Phone: (____) _____-_____ Does applicant live with you? [ ] Yes [ ] No

Financial Information for Applicant or Responsible Person

(Proof of income must be provided. Pay stub or tax return may be used for verification.)

Annual income: $_____ Proof of income attached: [ ]Pay stub [ ]TaxReturn

Qualifying Agency/Organization: _____ Size of Family Unit:_____

Certification

(The above financial information is correct to the best of my knowledge.)

Signature of Parent/Guardian: _____ Date:_____

Prepared by: _____ Position: _____

PBG Only

BF #: _____ Issue Date: _____ Follow-Up Date: _____ Claim Date: _____