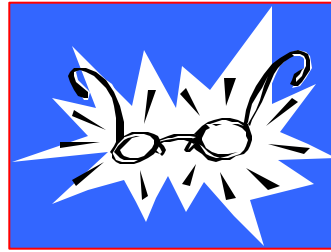


VISION PROPOSAL REQUEST FORM



Name of Company to be quoted: _____

Address _____

City _____ State _____ Zip Code _____

Phone # _____ Fax # _____

Please list all state provider listings needed: _____, _____, _____, _____, _____, _____, _____

Please mark all that is applicable:

Proposed effective date _____

Total number of eligible employees _____

Number of members requesting single coverage _____

Number of members requesting family coverage _____

Check one:

- Takeover group _____

If takeover group, current plan of benefits, number of years of previous vision coverage, current rates _____

- No previous coverage _____

Check one:

Voluntary _____ Employer Contribution _____

Producer's Name _____

Agency or Company _____

Address _____

City _____ State _____ Zip Code _____

Phone # _____ Fax # _____

E-mail address _____

VISION REQUEST FAX # 515-237-8221

SELECT NETWORKS

317 6TH AVE STE 1040 DES MOINES IA 50309

1-800-797-6282 Ext. 11

E-mail to: Steve Ellingboe :sellingboe@eyeplan.com

Visit our website: www.eyeplan.com